Swift Transportation Self-Funded Medical & Prescription Drug Plan

Plan Document & Summary Plan Description

Effective January 1, 2022

Table of Contents

Understanding Your Plan

Types of Coverage

Swift makes medical and prescription drug benefits available to its eligible employees and their eligible dependents under this Swift Transportation Self-Funded Medical & Prescription Drug Plan ("Plan"). This document describes the benefits available under the Plan and is the Plan's plan document for purposes of ERISA §402 and summary plan description for purposes of ERISA §102.

While the Plan provides medical and prescription drug benefits, not all services or prescription drugs are covered under the Plan. Rather, there are cost-share and other requirements as well as limitations and exclusions which are described in this document. You should read this document carefully to understand how much cost-share you will have to pay, the requirements for coverage, and what is (and is not) covered by the Plan.

As you read this document, please keep in mind many words (whether capitalized or not) have specific, defined meanings. You can find their meanings in the **Defined Terms** section or the section in which the word is used and defined.

Levels of Coverage

Eligible employees can choose coverage for themselves (or themselves and their eligible dependents) under one of the following levels of coverage available under the Plan:

- Value – PPO Value medical & Rx Value
- Core – PPO Core medical & Rx Core
- Premium – EPO Premium medical & Rx Premium

These three levels of coverage give you a choice as to what best fits your needs. For example, Premium generally has higher premiums but lower cost-share as compared to Value and Core which generally have lower premiums but higher cost-share. When you're eligible to enroll in the Plan, you'll receive information about the premiums for each level of coverage. For more information on cost-share, see "Your Cost-Share & Other Payments" in the **Prescription Drug Benefits** section and the **Medical Benefits Overview** section, as well as the applicable Cost-Share Summary at the end of this document.

In addition to different premiums and cost-share, the three options provide varying levels of coverage. For example, out-of-network services generally aren't covered under Premium (except in limited cases such as an emergency), whereas out-of-network services are generally covered under Value and Core (subject to cost-share and other requirements as well as limitations and exclusions). If using out-of-network providers is important to you, you should consider enrolling in Value or Core instead of Premium. With all levels of coverage, prescription drug benefits are in-network only.

Because this document describes all three levels of coverage available under the Plan, it's important while reading this document that you keep in mind the level you're enrolled in. Information in this document specific to a level you're not enrolled in doesn't apply to you. If you're not sure what level you're enrolled in, please look at your ID card. If you still have questions after looking at your ID card, see "Help With Your Benefits" below.

Network & Claims Administration

Blue Cross Blue Shield of Arizona ("BCBSAZ") provides certain administrative, claims and utilization management services, as well as a network of providers, for the medical benefits provided under the Plan. CVS Caremark provides certain administrative, claims and utilization management services, as well as a network of pharmacies,

for the prescription drug benefits provided under the Plan. These services are provided pursuant to administrative services agreements.

While BCBSAZ and CVS Caremark provide certain services, they (and their respective affiliates) do not insure, guarantee, or assume any financial risk or obligation to provide any benefits under the Plan. Rather, the Plan is self-funded, meaning all benefits payable under the Plan are paid from member contributions (i.e., your premiums) and Swift's general assets (see "Self-Funded Status" under "Additional Information" in the **Other Important Information** section).

Your Cost of Coverage

You're responsible for paying your portion of the premium for your (or your and your dependents') coverage. As indicated above, when you're eligible to enroll in the Plan, you'll receive information about the premiums for each level of coverage.

By enrolling, you're agreeing to pay your portion of the premium for your (or your and your dependents') coverage and authorizing Swift to deduct your portion from your pay. Payroll deductions will generally be taken on a pre-tax basis. If your pay is not sufficient for Swift to take the deduction, you're still responsible for paying your portion of the premium and your (or your and your dependents') coverage will end if you don't pay the amount you owe (see "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

In addition to your premiums, you're responsible for paying your cost-share for medical and prescription drug benefits (see "Your Cost-Share & Other Payments" in the **Prescription Drug Benefits** section and in the **Medical Benefits Overview** section, as well as the applicable Cost-Share Summary at the end of this document). You're also responsible for paying 100% of any services or prescription drugs to the extent they're not covered or not fully covered by the Plan.

Your ID Card & Explanation of Benefits

When you enroll in the Plan, you'll receive an ID card with basic information about your benefits, including who is covered, identification numbers, cost-share amounts, and important phone numbers and addresses. You should bring your ID card with you each time you seek services and purchase prescription drugs, and have your ID card available for reference if you contact the Claims Administrator for information. After you receive services, you should read your explanations of benefits (EOBs), monthly health statements, and/or other notices provided by the Claims Administrator, and notify the Claims Administrator if you see any differences between the amounts on these documents and what you actually paid.

Help With Your Benefits

If you have questions about your coverage or benefits, you can contact:

- Swift's Benefits Service Center – swift.benefitsnow.com or (844) 577-4333
- BCBSAZ – www.azblue.com, the BCBSAZ customer service number on your ID card, or Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
- CVS Caremark – www.caremark.com, the CVS Caremark customer service number on your ID card, or CVS Caremark, P.O. Box 52196, Phoenix AZ 85072-2196

If you lose your ID card, call (800) 232-2345.

You can call (800) 770-8973 if you're hearing impaired or (602) 864-4884 if you need assistance in Spanish.

For assistance with chiropractic benefits, contact the Chiropractic Benefits Administrator at (800) 678-9133 or American Specialty Health Networks, Inc., PO Box 509001, San Diego, CA 92150-9001.

For assistance with Telehealth Services, contact the Telehealth Services Administrator at (844) 606-1612, log in to your account at www.azblue.com and click on the BlueCareAnywhere link, or download the BlueCareAnywhere app on your phone.

Keeping the Plan Informed of Changes

It's your responsibility to keep the Plan Administrator and Claims Administrator informed of any changes which may affect your or your dependents' coverage or benefits under the Plan. You and your dependents are collectively referred to as "you" in this section. If you don't notify the Plan Administrator and Claims Administrator of changes, your coverage and/or benefits may be adversely impacted.

For example, changes in your address (or, if applicable, email) may result in your not receiving important information about your coverage or benefits. This is because notices and communications are sent to the address (or email if you've provided an email for electronic delivery) on file with the Plan Administrator and Claims Administrator. These notices/communications are deemed delivered (1) if hand-delivered, when hand-delivered, (2) if mailed, on the earlier of the day actually received by you or five days after deposit in the U.S. mail, postage prepaid, or (3) if transmitted electronically, on the earlier of the day of actual receipt or 24 hours after electronic transmission. The Plan Administrator and Claims Administrator don't have a duty to locate you, so you need to keep them informed of changes to your address (or, if applicable, email) to ensure you receive important notices and communications relating to your coverage and benefits.

As another example, changes in your information may affect your coverage and/or the amount of benefits payable under the Plan. If you don't notify the Plan Administrator and Claims Administrator about these changes, your coverage and benefits will still be determined based on the true facts and you may be responsible for repaying amounts that should not have been paid (see "Omissions, Misstatements, Misrepresentation or Fraud" and "Recovery of Incorrect & Over Payments" in the **Plan Administration** section). Examples of the types of changes which may affect coverage or benefits include, but aren't limited to: (1) your divorce or legal separation, (2) your dependent's reaching age 26, (2) your disabled dependent's no longer being disabled, or (4) coverage under another medical plan.

For certain events that are COBRA qualifying events, you must notify the COBRA Administrator (see "Qualifying Event & Election Notice Requirements" under "COBRA Continuation Coverage" in the **End of Coverage & COBRA Continuation Coverage** section). If you don't timely notify the COBRA Administrator, you'll lose the right to elect COBRA coverage.

Eligibility & Enrollment

Eligibility Requirements

Employees

All full-time employees (i.e., employees working 30 or more hours per week) who have completed the applicable waiting period are eligible to enroll in the Plan.

Your waiting period is:

- 60 days of continuous full-time employment if you're hired before January 1, 2022, as a trainee driver, as determined by Swift
- 30 days of continuous full-time employment if you're hired on or after January 1, 2022, as a trainee driver, as determined by Swift
- 30 days of continuous full-time employment if you're a full-time non-driver or you're a full-time driver who is not hired as a trainee driver, as determined by Swift

If you transfer from an ineligible class to an eligible class, you'll be eligible to enroll when you complete the applicable waiting period. Time you work in an ineligible class will not count toward satisfying the waiting period. However, if you transfer to Swift from a related Non-Participating Employer (for example, Knight Transportation), your full-time employment with the Non-Participating Employer will count toward satisfying the applicable waiting period.

If your coverage ends due to your termination of employment and you're rehired within 13 weeks, you won't have to re-satisfy the applicable waiting period to enroll (or reenroll). Rather, if you've already satisfied the applicable waiting period and are otherwise eligible to participate in the Plan, you'll be eligible to commence (or recommence) coverage under the Plan as of the first day of the month following your rehire date.

You also won't have to re-satisfy the applicable waiting period to enroll (or reenroll) if your coverage ends in connection with a period of time (such as a leave of absence) during which you don't perform any services and the period during which you don't perform any services does not exceed 13 weeks. However, your coverage generally won't end during a leave of absence unless you fail to make premium payments. If your coverage ends due to your failure to make premium payments and your leave is not an FMLA or military leave, you won't be eligible to enroll (or reenroll) in the Plan until the next enrollment period occurs (see also "Participation During Approved Leaves of Absence" below and "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

Former employees are not eligible to participate in the Plan, except as may otherwise be permitted through COBRA coverage (see "COBRA Continuation Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

To participate, you must enroll and there are deadlines for doing so (see "Enrollment Procedures" below).

Dependents

You may cover your:

- spouse to whom you're legally married
- child(ren) under 26 years of age
- disabled child(ren) age 26 or older if otherwise eligible and if he or she:
    - is covered under the Plan when he or she reaches age 26,
    - is totally disabled at the time he or she reaches age 26 (and continues to be totally disabled) due to a continuous physical or mental/behavioral impairment or condition, as determined by the Claims Administrator, **and**
    - is dependent on you for maintenance and support, as determined by the Claims Administrator

Your children include your:

- biological children
- legally adopted children (including children placed for adoption with you)
- stepchildren
- children for whom you're the legal guardian, including foster children placed with you by an authorized placement agency or court order
- children for whom coverage is required by a qualified medical child support order

The Plan may require that you provide proof of the dependent status (and, if applicable, disabled status) of any person you seek to enroll or reenroll as your dependent. The Plan may also require that you provide proof of the continued dependent status (and, if applicable, disabled status) of any person who is covered as your dependent. Required proof may include, but is not limited to, documentation such as a marriage license, federal tax return, birth certificate, social security number, or Social Security Administration determination of disability. Coverage of a person you seek to cover as a dependent may be retroactively canceled if you fail to provide the required proof,

in which case you may not be able to enroll (or reenroll) that person until the next enrollment period occurs (see "Enrollment Procedures" below).

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Except as may otherwise be permitted in the case of COBRA coverage (see "COBRA Continuation Coverage" in the **End of Coverage & COBRA Continuation Coverage** section), none of your dependents can be enrolled unless you're also enrolled and your dependents must be enrolled in the same level of coverage in which you're enrolled.

Benefit-Specific Eligibility

Benefits under the Plan are generally limited to eligible and enrolled employees and dependents (who are sometimes referred to as members). However, under the following limited circumstances, a non-member may be eligible to receive benefits:

- If a transplant recipient is a member and the donor is a non-member, the non-member donor may be eligible for limited benefits (see " Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures" in the **Description of Medical Benefits** section).
- If a non-member is pregnant with a baby that is to be adopted by a member, the non-member may be eligible for maternity benefits under the following circumstances (in which case the Plan's benefits are secondary to any coverage available to the non-member birth mother):
    - The child is adopted by the member within one year of birth,
    - The member is legally obligated to pay the costs of birth, **and**
    - The member notified the Claims Administrator that a court has certified the member as acceptable to adopt within 60 days of the court order or the effective date of the member's Plan coverage, whichever occurs later.

Enrollment Procedures

Initial Enrollment

To enroll when first eligible, you must request enrollment during your initial enrollment period or the grace period for you and any dependents you wish to cover. After you're hired or transferred into an eligible class (i.e., full-time employee status with Swift), you'll receive information on how to enroll during your initial enrollment period and the deadlines for doing so. Your initial enrollment period begins one week after you're hired or transferred into an eligible class and ends on the last day of the month during which you complete the applicable waiting period. The grace period is the month immediately following the month during which you complete the applicable waiting period. As shown in the example below, if you enroll during your initial enrollment period, your coverage will become effective earlier than if you enroll during the grace period.

Example: Mary is hired as a full-time non-driver on February 16, 2022. The last day of Mary's waiting period is March 18, 2022, making the last day of her initial enrollment period March 31, 2022. If Mary enrolls by March 31, 2022, her coverage will become effective April 1, 2022. If Mary does not enroll by March 31, 2022, she can still enroll during the month of April, but her coverage will not become effective until May 1, 2022. If Mary does not enroll by April 30, 2022, she will not be able to enroll until the next annual enrollment period (or, if applicable, special enrollment period or mid-year change) occurs.

Once you enroll, you cannot change or terminate your enrollment for yourself or your dependents until the next annual enrollment period (or, if applicable, special enrollment period or mid-year change) occurs. However, prior to then, your or your dependents' coverage may terminate for a specific reason; for example, if your employment ends (see "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

Annual Enrollment

Before the beginning of each calendar year, you'll have an opportunity to make or change your elections for the coming year, provided you're still eligible to participate at that time. This period of time is called the annual enrollment period, and you'll receive information on how to enroll or make changes during the annual enrollment period and the deadlines for doing so.

Your choices during the annual enrollment period will include:

- adding or dropping coverage for yourself or your dependents
- changing your level of coverage

If you're already enrolled and don't make any changes during the annual enrollment period, you'll be deemed to have elected to have your coverage (and any existing coverage for your dependents) for the current plan year apply to the next plan year, subject to any changes in default coverage (such as the level, type or scope of coverage). However, you'll still have to make an affirmative enrollment election if you want to add or change coverage or if you want to be eligible to receive certain contribution credits (i.e., premium reductions) or avoid certain contribution surcharges (i.e., premium increases). Therefore, even if you don't want to add or change coverage, you should still make an affirmative enrollment election during the annual enrollment period.

The choices you make during annual enrollment will be effective as of the first day of the plan year to which the annual enrollment period relates and cannot be changed until the next annual enrollment period (or, if applicable, special enrollment period or mid-year change) occurs. However, prior to then, your or your dependents' coverage may terminate for a specific reason; for example, if your employment ends (see "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

Special Enrollment

In certain cases, if you're otherwise eligible to enroll, you can enroll yourself and your dependents during a special enrollment period. A special enrollment period will apply in any of the following situations:

- you get married
- you have a new dependent child due to marriage, birth, adoption, or placement for adoption
- you become required, by a court order, to provide medical coverage for a dependent
- you didn't elect coverage for yourself or a dependent during your initial or annual enrollment period due to having coverage under another group health plan or health insurance and that coverage is lost because:
    - it was provided under a COBRA continuation provision, and coverage under that provision was exhausted, or
    - it was not provided under a COBRA continuation provision, and the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation or divorce, death, termination of employment, reduction in the number of hours of employment, the employer's decision to stop offering the group health plan to the eligible class to which the employee belongs, cessation of a person's status as a dependent, or employer contributions toward the coverage were terminated
- you or your dependent is covered under a Medicaid Plan or State CHIP Plan and your or your dependent's coverage under that plan ended because of your or your dependent's loss of eligibility for that coverage
- you or your dependent becomes eligible, under a Medicaid Plan or State CHIP Plan, to receive financial assistance with premiums for coverage under this Plan

The special enrollment period will begin on the date the event happens that gives rise to the special enrollment period (for example, the date you get married, the date you obtain a new dependent or the date the person loses other coverage) and will end 31 days later (or 60 days later if the event giving rise to the special enrollment period

is the loss of coverage under a Medicaid or State Plan or eligibility under a Medicaid or State Plan for financial assistance with premiums under this Plan). If you enroll yourself or your dependents during the special enrollment period, coverage will be effective as of the date the event happened, except in the case of a court order where coverage will be effective when enrollment actually occurs. Remember, your dependents cannot be enrolled for coverage unless you're already enrolled or you also enroll yourself during the special enrollment period. Also, the Plan may require that you provide proof of the event and proof of the dependent status of any person who you seek to enroll as your dependent.

A child is automatically eligible for coverage for the first 31 days after the date of birth, adoption or placement for adoption, and will be automatically added to the Plan so long as the parent or guardian covered under the Plan remains eligible for coverage during that period and the newborn or child adopted or placed for adoption is otherwise an eligible dependent under the Plan. If an additional premium is required for the newborn or adopted child, and the member enrolls the child within 31 days of the birth, adoption, or placement for adoption, the Plan will continue coverage for the child after the 31-day period. If an additional premium is required and the member doesn't enroll the child, the Plan will remove the child after 31 days. If an additional premium is not required for the child, the Plan will continue coverage for the child after the 31-day period ends, unless the member notifies the Plan in writing (within the 31-day period) to not continue coverage for the child.

Generally, once you enroll, you cannot change or terminate your enrollment until the next annual enrollment period (or, if applicable, another special enrollment period or a mid-year change) occurs. However, prior to then, your or your dependents' coverage may terminate for a specific reason; for example, if your employment ends (see "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

If you don't enroll yourself or your dependents during the special enrollment period, you won't be able to enroll until the next annual enrollment period (or, if applicable, another special enrollment period or a mid-year change) occurs.

Mid-Year Changes

As described in "Initial Enrollment", "Annual Enrollment" and "Special Enrollment" above, enrollment or changes in enrollment during the plan year are generally not allowed. "Special Enrollment" above describes certain situations where you can enroll your dependents (if you're already enrolled) or yourself and your dependents (if you're not already enrolled) during the plan year.

This "Mid-Year Changes" subsection describes additional, limited situations when you can enroll or change enrollment during a plan year. To enroll or make a change under this "Mid-Year Changes" subsection:

- one of the events described below must occur
- the event must impact your or your dependent's eligibility for coverage
- you must make the change (in the form and manner required by the Plan Administrator) within 31 days of the date on which the event occurs
- your change must be consistent with the event

Change in Legal Marital Status

This includes getting married, divorced or legally separated. The ability to enroll yourself and your dependents in the Plan if you get married is described in "Special Enrollment" above. Your marriage may also allow you to drop coverage if the reason you're dropping coverage under the Plan is because you'll have coverage under your new spouse's plan. If you get divorced or legally separated, you can drop coverage for your former spouse, but you cannot drop coverage for yourself (or for your dependent children unless your former spouse becomes legally obligated to provide medical coverage for your dependent children).

Change in Employment Status or Work Schedule

This includes starting or terminating employment, a strike or lock-out, or the start of or return from an unpaid leave of absence. Remember, these events don't allow you to make a mid-year change unless the event affects eligibility. Generally, the start of or return from an unpaid leave of absence will not affect eligibility, meaning that a mid-year change will generally not be allowed (see "Participation During Approved Leaves of Absence" below). If a mid-year change is allowed because the event does affect eligibility, the change must be consistent with the event.

The ability to enroll yourself and your dependents in the Plan if you didn't enroll due to other coverage and the other coverage is lost is described in "Special Enrollment" above.

Under this "Mid-Year Changes" subsection, you can enroll an eligible person in the Plan if a change in employment affects that person's eligibility for coverage under another health plan. For example, if your spouse and dependent children are enrolled in your spouse's employer's plan and lose coverage due to your spouse's termination of employment, you can enroll your spouse and dependent children in the Plan ***if*** you're already enrolled in the Plan (or, if you're not already enrolled in the Plan, you also lost coverage in your spouse's employer's plan and you enroll yourself in the Plan). Also, if your spouse gets a new job and, as a result, your spouse and your dependent children become eligible under your spouse's employer's plan, you can drop coverage for your spouse and dependent children under the Plan ***if*** your spouse and dependent children are enrolled in your spouse's employer's plan.

Change in Medicare or Medicaid Coverage

This includes becoming enrolled in Medicare or Medicaid or losing coverage under Medicare or Medicaid. Coverage for the person who becomes enrolled in Medicare or Medicaid can be dropped under the Plan. A person who loses coverage under Medicare or Medicaid can be enrolled in the Plan. Remember, if the person losing coverage is your spouse, you cannot enroll your spouse under this "Mid-Year Changes" subsection unless you're already enrolled in the Plan.

Change During Another Plan's Annual Enrollment Period

This change applies only if your dependent's employer's health plan has a different annual enrollment period than this Plan's annual enrollment period. You can drop coverage under the Plan for any person who becomes covered under your dependent's employer's plan during its annual enrollment period. You can add coverage under the Plan for any person who loses coverage under your dependent's employer's plan during its annual enrollment period. For this purpose, "dependent" means your spouse, your dependent child, or both, and "person" means only dependents who are otherwise eligible to participate in the Plan.

Change in Your Residence

Since coverage under the Plan is generally not affected by where you live, a change in your residence typically won't result in your no longer being eligible for the level of coverage in which you're enrolled. However, if a change in residence were to affect your eligibility, you'd be able to elect a different level of coverage for which you're eligible based on your new residence. Remember, a mid-year change in election must be made within 31 days of the event (i.e., change in your residence). If you're not already enrolled in the Plan, a change in your residence will not permit you to enroll in the Plan mid-year.

Participation During Approved Leaves of Absence

General Rules for Leaves

Special rules (discussed below) apply to FMLA and military leaves. For all other leaves, if you go on an approved leave of absence (whether paid or unpaid), your (or your and your dependents') coverage under the Plan will continue during your approved leave, subject to your continued payment of premiums. If you're on a paid leave, your premium payments will continue to be taken from wages paid to you by Swift (but not from amounts paid to

you by a third party, such as workers' compensation payments). If the payments you're receiving while on leave are from a third party (i.e., not Swift) or if you're on an unpaid leave, you must make arrangements to pay the premiums that become due during your leave.

The coverage you (or you and your dependents) will have during your approved leave will be the same as similarly situated employees who are not on leave. For example, if during your leave there is a change in the benefits offered under the Plan or the premiums, that change will apply to you to the same extent as it applies to similarly situated employees who are not on leave. Also, the eligibility, enrollment and end of coverage provisions described in "Eligibility Requirements" and "Enrollment Procedures" above and in "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section below (including any changes to those provisions) will apply to you to the same extent as they apply to similarly situated employees who are not on leave.

If you fail to make a premium payment, your (or your and your dependents') coverage will end (see "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section). Your coverage won't be automatically reinstated when you return from leave and you won't be eligible to reenroll in the Plan until the next enrollment period occurs (see "Enrollment Procedures" above).

Special Rules for FMLA Leaves

If you go on an approved, paid FMLA leave your (or your and your dependents') coverage under the Plan will continue during your approved leave, subject to your continued payment of premiums. During your leave, your premium payments will continue to be taken from wages paid to you by Swift (but not from amounts paid to you by a third party, such as workers' compensation payments). If the payments you're receiving while on leave are from a third party (i.e., not Swift), you must make arrangements to pay the premiums that become due during your leave.

If you go on an unpaid FMLA leave, you'll have the opportunity to elect to terminate your (or your and your dependents') coverage while on leave. If you don't elect to terminate your (or your and your dependents') coverage while on leave, coverage will continue during your approved leave, subject to your continued payment of premiums. You must make arrangements to pay the premiums that become due during your leave.

As with other types of leave, the coverage you (or you and your dependents) will have during your approved FMLA leave will be the same as similarly situated employees who are not on leave, as described above in "General Rules for Leaves". If you fail to make premium payments while on FMLA leave, your (or your and your dependents') coverage will end (see "End of Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

If your (or your and your dependents') coverage ends while you're on FMLA leave, your (or your and your dependents') coverage will be automatically reinstated when you return from FMLA leave. However, you (or you and your dependents) will still not have any coverage under the Plan from the date your (or your and your dependents') coverage ended until the date you returned from FMLA leave.

Special Rules for Military Leaves

For military leaves covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), coverage will continue to the extent required by and in accordance with the requirements of USERRA.

End of Coverage & COBRA Continuation Coverage

End of Coverage

Employees

Your coverage (as an employee) will end on the first to occur of:

- when your employment with Swift ends, whether due to your death or otherwise
- when you become employed in a position that's not eligible for coverage under the Plan, whether due to a transfer of employment/position or a change in the Plan's eligibility requirements
- when you fail to make a premium payment for your coverage
  Note: if coverage ends for this reason, you won't be eligible to reenroll yourself (or, if applicable, yourself and your dependents) until the next enrollment period occurs (see the **Eligibility & Enrollment** section)
- the effective date of your election to no longer be covered under the Plan, whether affirmative or by default
  Note: the times during which you can make this type of election are limited and if you make this election, you won't be eligible to reenroll until the next enrollment period occurs (see the **Eligibility & Enrollment** section)
- if/when the Plan is terminated

If your coverage ends, you may have the right to elect to continue your coverage for a limited period of time at your own cost (see "COBRA Continuation Coverage" below).

Dependents

Your dependent's coverage will end on the first to occur of:

- when your coverage (as an employee) ends
- when your dependent becomes eligible to be covered as an employee
- when you fail to make a premium payment for your dependent's coverage
  Note: if coverage ends for this reason, you won't be eligible to reenroll your dependent until the next enrollment period occurs (see the **Eligibility & Enrollment** section)
- the effective date of your election for your dependent to no longer be covered under the Plan, whether affirmative or by default
  Note: the times during which you can make this type of election are limited and if you make this election, you won't be eligible to reenroll your dependent (in addition to yourself) until the next enrollment period occurs (see the **Eligibility & Enrollment** section)
- when your dependent no longer qualifies as a "dependent" under the Plan, for example, due to reaching age 26, no longer being a disabled dependent, or a change to the Plan's dependent eligibility requirements
  Note: if your dependent no longer qualifies as an eligible dependent due to reaching age 26, your dependent's coverage will end on the last day of the month during which he or she reached age 26
- if your dependent child is covered under the Plan due to a qualified medical child support order, when coverage is no longer required under that order

If your dependent's coverage ends, your dependent (or you on your dependent's behalf) may have the right to elect to continue coverage for a limited period of time at your own cost (see "COBRA Continuation Coverage " below).

Impact on Precertification & Claims Processing

The Plan Administrator will notify the Claims Administrator as soon as administratively possible after your or your dependent's coverage ends. Absent eligibility for and election of continued coverage for a limited period of time

(see "COBRA Continuation Coverage" below), any services received after coverage ends are not covered under the Plan, even if due to an accident, injury, or illness that occurred or existed while coverage was in effect. This means if the Claims Administrator quotes benefits, provides precertification, or pays claims after coverage has ended, the quote or precertification will be null and void and the payment will be considered an overpayment (see "Recovery of Incorrect & Over Payments" in the **Plan Administration** section).

COBRA Continuation Coverage

Under certain circumstances, if your or your dependents' coverage under the Plan ends, you'll have the right to elect to continue coverage for a limited time at your own cost. This limited continuation coverage is called COBRA continuation coverage or COBRA coverage because a federal law entitled the Consolidated Omnibus Budget Reconciliation Act of 1985 gives you the right to this coverage. The COBRA coverage rules are summarized below, but you'll also receive a separate notice describing your COBRA rights.

Please note there may be other medical coverage options for you or your dependents. For example, you or your dependents might qualify for coverage through the Health Insurance Marketplace, Medicaid, or another group health plan (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Who Can Elect COBRA Coverage

Each person who loses regular coverage under the Plan due to a qualifying event is a qualified beneficiary who can elect COBRA coverage. When a qualifying event occurs, COBRA coverage must be offered to each person who is a qualified beneficiary.

If you're an employee, you'll become a qualified beneficiary if you lose coverage under the Plan because:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct

If you're an employee who timely elects COBRA coverage, a child who becomes your dependent child by birth, adoption or placement for adoption during your COBRA coverage period will also be considered a qualified beneficiary.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose coverage under the Plan because:

- the employee-spouse's hours of employment are reduced
- the employee-spouse's employment ends for any reason other than his or her gross misconduct
- you become divorced or legally separated from the employee-spouse
- the employee-spouse dies, or
- the employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)

If you're a dependent (but not a spouse) of an employee, you'll become a qualified beneficiary if you lose coverage under the Plan because:

- the parent-employee's hours of employment are reduced
- the parent-employee's employment ends for any reason other than his or her gross misconduct
- the parents become divorced or legally separated
- the parent-employee dies
- the parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both), or
- you no longer meet the requirements to be eligible for coverage under the Plan as a dependent

Qualifying Event & Election Notice Requirements

If the initial (or second) qualifying event is divorce or legal separation or a person's no longer meeting the requirements to be covered as a dependent, you must notify the COBRA Administrator within 60 days. The written notice can be sent via first class mail or hand-delivered and must include your name, the qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents. If you don't notify the COBRA Administrator on time of an initial qualifying event, the person who would otherwise be entitled to COBRA coverage will lose his or her right to COBRA coverage. If you don't notify the COBRA Administrator on time of a second qualifying event, the person who might otherwise be entitled to an extension of the COBRA coverage period will lose his or her right to an extension.

The other qualifying events will be reported by Swift to the COBRA Administrator within 30 days.

Within 14 days after receiving notice of a qualifying event, the COBRA Administrator will send a notice either:

- providing you with information on how to elect COBRA coverage and the deadline for doing so (which is generally 60 days after this information is provided to you), or
- explaining to you why COBRA coverage is not available

Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered employees may elect COBRA coverage on behalf of their spouses who are qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children who are qualified beneficiaries.

If you don't timely elect COBRA coverage, you'll lose your right to do so.

COBRA Coverage Period

The length of the COBRA coverage period depends on which qualifying event(s) occur and whether an intervening event occurs.

COBRA coverage will automatically end at the end of the applicable maximum period described below, without any additional notice to the qualified beneficiary. If COBRA coverage ends sooner due to an intervening event, the affected person will be notified by the COBRA Administrator as soon as practicable after the COBRA Administrator determines coverage will end early. This written notice will explain the reason COBRA coverage terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have to elect alternate or conversion coverage.

18-Month Maximum Period

The COBRA coverage period will be for a maximum of 18 months for the following qualifying events:

- the employee's reduction in hours
- the employee's end of employment due to any reason other than his or her gross misconduct

In certain situations, the 18-month period may be extended to 29 months or 36 months (see "29-Month Maximum Period" and "36-Month Maximum Period" below).

29-Month Maximum Period

The 18-month period described above may be extended to a maximum of 29 months if a qualified beneficiary (or one of his or her family members who is also a qualified beneficiary) is disabled (as determined by the Social Security Administration) at the time the qualifying event occurs or becomes disabled within the first 60 days of the initial 18-month COBRA coverage period. To be entitled to this extension, you must notify the COBRA Administrator within 60 days after you receive notice from the Social Security Administration that the person is disabled. Also, this notice must be provided before the initial 18-month COBRA coverage period ends.

If the person ceases to be disabled, you must notify the COBRA Administrator within 30 days after you receive notice from the Social Security Administration that the person is no longer disabled. In this case, if the initial 18-month period has not ended, there will be no extension. If the initial 18-month period has ended, coverage will end within 30 days after the notice is provided.

36-Month Maximum Period

For all qualifying events (other than the employee's reduction in hours or end of employment due to any reason other than the employee's gross misconduct), the COBRA coverage for a spouse or dependent will be for a maximum of 36 months.

Also, a spouse's or dependent's 18-month COBRA coverage period may be extended under the following circumstances:

- If an 18-month qualifying event (such as the employee's reduction in hours) occurs and a 36-month qualifying event (such as a divorce) later occurs, the 18-month COBRA coverage period may be extended to 36 months from the date of the **initial** qualifying event.
- If an employee becomes entitled to Medicare, but there is no loss in coverage at that time, and a loss in coverage later occurs because of an 18-month qualifying event (such as the employee's reduction in hours), the 18-month COBRA coverage period may be extended to 36 months from the date of Medicare entitlement. However, if the 18-month COBRA coverage period would end after 36 months from the date of Medicare entitlement, there will be no extension of the 18-month COBRA coverage period.

Intervening Events

Certain events will cause COBRA coverage to end before the applicable maximum period described above. These events are:

- Swift's ceasing to provide group health coverage to any of its employees
- your failure to pay for COBRA coverage (see "Paying for COBRA Coverage" below)
- your becoming entitled to Medicare after electing COBRA coverage
- your becoming covered under another group health plan after electing COBRA coverage
- during the 11-month extension of the COBRA coverage period due to disability, the disabled person's ceasing to be disabled, as determined by the Social Security Administration

Generally, if one of the above intervening events occurs, COBRA coverage will end on the date the intervening event occurs (or, in the case of a failure to pay for COBRA coverage, on the last day for which coverage was paid).

Paying for COBRA Coverage

By law, any person who elects COBRA coverage will have to pay for the full cost of coverage. This is the full cost of coverage for similarly situated active employees and families (i.e., the entire premium amount, including both the credit Swift might otherwise provide and the employee's portion of the premium), plus an additional 2%. If the 18-month period of COBRA coverage is extended because of disability, the required amount may increase by 50% if the disabled person is covered during the 11-month additional COBRA coverage period.

Each person will be told the exact dollar charge for COBRA coverage in effect at the time he or she becomes entitled to elect it. The cost of COBRA coverage may be subject to future increases during the period it remains in effect.

The initial payment for COBRA coverage is due to the COBRA Administrator within 45 days after COBRA coverage is elected. If this payment is not made when due, COBRA coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made by the due date or within the grace period, COBRA coverage will be canceled as of the due date.

Prescription Drug Benefits

Under the prescription drug benefit, the Plan covers the cost of certain outpatient prescription drugs, subject to the cost-share requirements (i.e., amounts you must pay in addition to premiums), prior authorization requirements (where applicable), limitations and exclusions discussed below. Please note that certain medications are covered under the Plan as a medical benefit (see the **Description of Medical Benefits** section).

Basic Requirements for Covered Prescription Drugs

To be covered by the Plan under the prescription drug benefit, a prescription drug generally must be:

- a prescription covered by the Plan's prescription drug benefit which is not excluded or in excess of Plan limits (see "Limitations & Exclusions" below),
- medically or dentally necessary for the care and treatment of an illness or injury, as determined by the Claims Administrator, unless expressly covered (for example, as a standard preventive drug which is a prescription drug),
- prescribed by a physician, dentist or optometrist and not usually provided without charge,
- dispensed while the Plan is in effect and while you're enrolled in the Plan, **and**
- dispensed by an in-network pharmacy (see "In-Network Pharmacies" below).

Retail prescriptions (including refills) are limited to a 30-day supply (except as otherwise provided under "CVS Caremark Maintenance Choice Program" below). Mail order prescriptions (including refills) are limited to a 90-day supply. In addition, the Claims Administrator develops other quantity limitations to ensure safe and appropriate medication use. Regardless of the amount prescribed by your provider, the amount dispensed will be based on the recommended limitation. For more information, call CVS Caremark at (855) 305-3016.

Your Cost-Share & Other Payments

Cost-share refers to the amount (in addition to premiums) you're responsible for paying for covered prescription drugs. You're also responsible for paying 100% of the cost of a prescription drug to the extent the drug is not covered or not fully covered by the Plan. For example, prescription drugs dispensed by an out-of-network pharmacy are not covered by the Plan, meaning you'll pay 100% of the cost for those drugs and the Plan will pay 0%.

Generally, your cost-share for covered prescription drugs depends on:

- the level of coverage your enrolled in (i.e., Value, Core, or Premium)
- the type of prescription you fill or refill (see the discussion below regarding the standard preventive drug list; see also "Generic & Brand Name Drugs" below) **and**
- where you fill or refill your prescription (see "In-Network Pharmacies" below)

If you're enrolled in Core or Premium, your cost-share will be in the form of a copay. A copay is a specific dollar amount you must pay to the pharmacy when you get your prescription filled (or refilled).

If you're enrolled in Value, your cost-share for generic drugs will be in the form of a copay, but your cost-share for brand-name drugs (whether preferred or non-preferred) will be in the form of coinsurance. Coinsurance is a percentage of the cost that you pay. There is no deductible for prescription drug benefits. There is also no out-of-pocket maximum for prescription drug benefits, except for fertility medications. The out-of-pocket maximum for fertility medications is combined with the out-of-pocket maximum for medical benefits (see "Your Cost Share & Other Payments" in the **Medical Benefits Overview** section), and there's an individual life time maximum for fertility medications (see "Limitations & Exclusions" below).

For more information about your cost-share, see the applicable Cost-Share Summary at the end of this document for the level of coverage you're enrolled in. If you don't know what level of coverage you're enrolled in, look at your ID card.

Regardless of your cost-share, certain prescription drugs which are on the standard preventive drug list and covered under the prescription drug benefit are available at no cost to you (e.g., there's no copay or coinsurance you have to pay). For the standard preventive drug list, call the CVS Caremark customer service number on your ID card or go to www.caremark.com/portal/asset/NoCost_Preventive_List.pdf. Please note that since the prescription drug benefit doesn't include inpatient prescription drugs, standard preventive drugs provided in an inpatient setting will be available under the Plan at no cost to you as a medical benefit, subject to all other applicable requirements, limitations, maximums and exclusions.

Generic & Brand Name Drugs

As indicated above, your-cost share for covered prescription drugs depends, in part, on whether the prescription drug is a generic drug or a brand-name drug. You'll generally pay the lowest amount for generic drugs, a higher amount for preferred brand name drugs, and the highest amount for non-preferred brand name drugs. The designation of a prescription drug as generic, preferred brand name or non-preferred brand name is determined by the Claims Administrator. The Claims Administrator may change the designation of one or more prescription drugs at any time.

Since your-cost share is lower for generic drugs, you might want to ask your provider to prescribe a generic drug (or authorize a generic substitution) when medically appropriate. If your provider prescribes a brand name drug and does not authorize a generic substitution (and in any other situation where you receive a brand name drug), you'll pay the applicable cost-share for the brand name drug (see the applicable Cost-Share Summary at the end of this document).

Generic Drugs

Generic drugs are approved to be as safe and effective as their brand name counterparts and typically cost less than brand name drugs. Generic drugs contain the same active ingredients and are available in the same strength and dosage form as their brand name counterparts. The U.S. Drug and Food Administration (FDA) regulates the manufacture of all generic drugs, which helps ensure their strength, quality, and purity. The FDA also requires generic drugs to be absorbed into the body at the same rate and to the same extent as the branded product, which ensures that generic and branded products provide the same effectiveness in children, adults, and the elderly.

Preferred Brand Name Drugs

Preferred brand name drugs are a select list of medications on the Claims Administrator's preferred drug list that are clinically appropriate and cost-effective to meet individual needs. For the Claims Administrator's preferred drug list, call the CVS Caremark customer service number on your ID card or log in to your account at www.caremark.com.

Non-Preferred Brand Name Drugs

Non-preferred brand name drugs are brand name drugs that are not part of the Claims Administrator's preferred drug list. You pay the most for non-preferred brand name drugs.

Prior Authorization

Prior authorization requires a drug's prescribed use to be evaluated against a predetermined set of criteria before the prescription will be covered under the Plan. In addition to the quantity limitations described above in "Basic

Requirements for Covered Prescription Drugs", certain drugs or drug classes will require prior authorization for you to receive coverage for them. The Claims Administrator will notify you if seek to fill (or refill) a drug that requires prior authorization. You can avoid delays and interruptions in your therapy by asking your provider to call the CVS Caremark Prior Authorization Department at (888) 413-2723. The request will be evaluated to determine if the prescribed drug qualifies for coverage under the Plan. If you don't meet the criteria standards and still wish to take the medication, you'll be responsible for the entire cost of the drug.

In-Network Pharmacies

Retail Pharmacies

You can fill (or refill) your covered prescriptions at an in-network retail pharmacy. Retail pharmacies are good for short-term prescriptions where the initial prescription and any refills are each limited to a 30-day supply. If you have a prescription for a long-term maintenance medication, you can use the CVS Caremark Maintenance Choice Program or the mail-order pharmacy (both discussed below) to get a 90-day supply which will generally cost you less than what it would cost to get three 30-day supplies. Specialty medications must be filled (and refilled) using the CVS Caremark Specialty Pharmacy Services described below.

To find an in-network retail pharmacy, go to www.caremark.com or call the CVS Caremark customer service number on your ID card.

To fill (or refill) your prescription at an in-network retail pharmacy:

- go to an in-network retail pharmacy
- present your prescription to the pharmacist
- present your ID card to the pharmacist
- sign for and receive your prescription

Mail-Order Pharmacy

You can fill (or refill) your prescriptions for long-term maintenance medications through the mail-order pharmacy. Over-the-counter (i.e., non-prescription) drugs cannot be ordered through the mail-order pharmacy. Also, specialty medications must be filled (or refilled) using the CVS Caremark Specialty Pharmacy Services described below.

To use the mail-order pharmacy:

- Ask your physician to write a prescription for a 90-day supply, plus refills, so you can submit it directly to the mail-order pharmacy with your form.
- If you need medication immediately, ask your physician for two prescriptions:
  - One for an immediate 30-day supply which you can have filled at an in-network retail pharmacy, and
  - One for a 90-day supply which you can have filled through the mail order pharmacy.
- Sign in or register at www.caremark.com/startnow and follow the instructions to fill a new 90-day prescription, or call CVS Caremark at (855) 305-3016.
- Complete the mail-order form and send it to CVS Caremark, along with your original prescription and your cost-share amount.
- The mail-order pharmacy will then mail your prescription drug(s) to you, along with reorder instructions.

To refill a long-term maintenance medication, you can use the process described above, call CVS Caremark at (855) 305-3016 for their automated toll-free line which is available 24 hours a day, seven days a week or log on to www.caremark.com to place a refill order. Remember, to be eligible for a refill, you must have used up at least 75% of your 90-day supply.

CVS Caremark Maintenance Choice Program

The CVS Caremark Maintenance Choice Program gives you another option for filling (or refilling) your long-term maintenance medications. Instead of using the mail-order pharmacy discussed above, you can get up to a 90-day supply of your long-term maintenance medications filled (or refilled) at a CVS retail pharmacy. Your cost-share for using a CVS retail pharmacy for long-term maintenance medications will be the same as the mail-order pharmacy.

The CVS Caremark Maintenance Choice Program is not available at any in-network pharmacy. Rather, it's limited to CVS retail pharmacies. Therefore, if you want to use the CVS Caremark Maintenance Choice Program, you must have your prescription filled (and refilled) at a CVS retail pharmacy. Remember, to be eligible for a refill, you must have used up at least 75% of your 90-day supply.

CVS Caremark Specialty Pharmacy Services

To be covered, certain specialty drugs must be filled (refilled) using the CVS Caremark Specialty Pharmacy Services, and an in-network retail pharmacy must do the first fill. CVS Caremark Specialty Pharmacy Services is a full-service specialty pharmacy that provides specialty injectable and oral drugs for chronic conditions. CVS Caremark provides these products directly to you along with personalized service and educational support for your specific therapy.

Conditions covered include Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Allergic Asthma, Osteoporosis, Cystic Fibrosis, Hepatitis C, Crohn's Disease, Pulmonary Hypertension, Psoriasis, and other conditions as determined by CVS Caremark. To learn more about CVS Caremark Specialty Pharmacy Services, go to www.caremark.com or to get started with the service, call Caremark Connect at (800) 237-2767. All specialty agents are subject to Specialty Guideline Management review. Specialty Guideline Management is a program that helps to ensure appropriate utilization for specialty medications based on evidence-based medicine guidelines. Patient progress is continually assessed to determine whether appropriate therapeutic results are achieved. You may call (866) 814-5506 to request a Specialty Guideline Management review.

CVS Caremark's care management process, provided through its affiliate CVS Specialty, will provide you the support and resources necessary to navigate these benefit changes, including helping you pursue third party copay assistance for these particular prescribed drugs via a third party called PrudentRx. This program is offered as part of the Plan's exclusive specialty pharmacy network with CVS Caremark's affiliate CVS Specialty, and eligibility for the PrudentRx Co-Pay Program described below is dependent on the applicable terms and conditions required by that program and are subject to change. The list of specialty drugs eligible for specialty copay assistance programs is also subject to change. If obtained, copay assistance support doesn't count toward any otherwise applicable out-of-pocket maximum. If you choose not to participate in the care management process, you'll be responsible for 100% of the applicable copay.

PrudentRx Co-Pay Program for Certain Specialty Drugs

To help you with the cost of certain specialty drugs, the Plan offers the PrudentRx Co-Pay Program. The program applies to drugs on the program's specialty drug list which is subject to change. Enrollment is voluntary but you can lower your costs by enrolling in the program because there's no cost-sharing (e.g., no copay or coinsurance) for your covered specialty drugs if you're enrolled in the program. If you're eligible but choose not to enroll in the program, you'll have the pay the normal cost-share amount.

If you enroll, PrudentRx will help you enroll in any applicable drug manufacturer copay assistance programs whereby the manufacturer pays all or most of the drug's cost. Copay assistance support doesn't count toward any otherwise applicable out-of-pocket maximum. Whether or not there's an applicable copay assistance program, you won't pay any cost-sharing for your covered specialty drugs if you're enrolled in the PrudentRx Co-Pay Program.

If you're taking a drug on the PrudentRx Co-Pay Program's specialty drug list, PrudentRx may contact you directly about enrolling in the program. You can also enroll in the program or get more information about the program or the specialty drug list by calling PrudentRx at (800) 578-4403.

Note: There is small subset of drugs not available via CVS Specialty due to a limited distribution arrangement. These drugs are excluded from the PrudentRx Co-Pay Program but may still be covered by the Plan subject to otherwise applicable cost-sharing.

Limitations & Exclusions

The Plan doesn't pay benefits for every type of prescription drug. Rather, the Plan has certain limitations and exclusions, and amounts in excess of a limitation or amounts for excluded items are not covered by the Plan.

Limitations

- 30-day supply limit for each fill (and each refill) by an in-network retail pharmacy (except for fills/refills using the CVS Caremark Maintenance Choice Program)
- 90-day supply limit for each fill (and each refill) using the mail-order pharmacy or the CVS Caremark Maintenance Choice Program
- In addition to the above limits, prescriptions are limited by quantity limitations determined by the Claims Administrator
- To be eligible for a refill, you must have used up at least 75% of your 30-day (or, if applicable, 90-day) supply
- $5,000 per individual life time maximum for fertility medications
- For generic step therapy, a cost-effective generic alternative must be tried first before a targeted single-source brand will be covered. For more information about the drug classes subject to this limitation, visit www.caremark.com or call the CVS Caremark customer service number on your ID card.

Exclusions

- Drugs which are not outpatient prescription drugs
- Drugs that do not meet the basic requirements for coverage (see "Basic Requirements for Covered Prescription Drugs" above)
- Drugs that are not on the Claims Administrator's formulary
- Specialty drugs if not filled/refilled using the CVS Caremark Specialty Pharmacy Service
- Drugs which require prior authorization if prior authorization is not obtained
- Any other applicable exclusions in the **General Exclusions** section

Medical Benefits Overview

Basic Requirements for Covered Services

To be covered by the Plan, a service or item generally must be:

- a service or item expressly covered by the Plan (see the **Description of Medical Benefits** section),
- medically or dentally necessary (see the **Defined Terms** section) as determined by the Claims Administrator, unless expressly covered (for example, covered as a preventive service),
- not excluded (see the **Description of Medical Benefits** section and the **General Exclusions** section),
- not experimental or investigational (see the **Defined Terms** section) as determined by the Claims Administrator (does not apply to covered services as part of an approved clinical trial),
- pre-certified if precertification is required (see "Precertification" below),

- provided while the Plan is in effect and while the person claiming benefits is eligible for benefits under the Plan,
- provided by an eligible provider (see the **Defined Terms** section) acting within the provider's scope of practice as determined by the Claims Administrator, **and**
- in most cases if you're enrolled in Premium, provided by an in-network provider (see the **Medical Providers** section) except a network provider is not required for emergency services.

The Claims Administrator's decisions about medical or dental necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that the Claims Administrator decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. Also, not all medically necessary services are covered benefits under the Plan. Rather, the Plan has cost-share and other requirements as well as limitations and exclusions from coverage. As a result, a service may be medically necessary but still limited or excluded from coverage under the Plan.

In addition to other limitations and exclusions, some benefits may have a specific benefit maximum (or limit) based on the number of days or visits, type, timeframe (calendar year), or other factors. If you reach a benefit maximum, any further services are not covered under that benefit and you may have to pay the provider's billed charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you'll be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim. All benefit maximums are included in the applicable benefit description (see the **Description of Medical Benefits** section).

Your Cost-Share & Other Payments

Cost-share refers to the amount (in addition to your premiums) you're responsible for paying for covered services under the Plan. You're also responsible for paying 100% of any services to the extent they're not covered or not fully covered by the Plan. For example, if you receive covered services in excess of a benefit maximum, you're responsible for paying all amounts in excess of the benefit maximum. If you receive noncovered services, you're responsible for paying 100% of the noncovered services.

The Claims Administrator uses your claims to track whether you've met your cost-share obligations. Claims are applied based on the order in which they're processed, not based on the date of service. The types of cost-share are summarized below. Your actual cost-share will depend on the level of coverage (i.e., Value, Core, or Premium) you're enrolled in (see the applicable Cost-Share Summary at the end of this booklet). If you're not sure what level you're enrolled in, please look at your ID card.

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Copay

A copay is a specific dollar amount you must pay to the provider for some covered services. If a copay applies to a covered service, you must pay it when you receive services. Different services may have different copay amounts (see the applicable Cost-Share Summary at the end of this document). Usually, if a copay doesn't apply, you'll pay the applicable deductible and coinsurance.

Calendar-Year Deductible (Individual and Family)

A calendar-year deductible is the amount each member must pay for certain covered services each January through December before the Plan begins to pay its portion of the allowed amount for those services (see the applicable Cost-Share Summary at the end of this document).

If you have family coverage, there is also a calendar-year deductible for the family. Amounts counting toward an individual's calendar-year deductible will also count toward any family deductible. When the family satisfies its calendar-year deductible, it also satisfies the deductible for all the individual members. An individual member cannot contribute more than his or her individual deductible toward the family's deductible.

The deductible is calculated based on the Plan's allowed amount. Amounts you pay for copays, precertification charges, and balance bills don't count toward the deductible.

If you're enrolled in Value or Core, there are separate in-network and out-of-network calendar-year deductibles. This means you have to meet the in-network deductible for in-network services and the out-of-network deductible for out-of-network services. It also means in-network expenses don't count toward the out-of-network deductible (and vice versa).

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible (see the applicable Cost-Share Summary at the end of this document). The Claims Administrator subtracts any applicable precertification charges from the allowed amount before calculating coinsurance.

The Claims Administrator normally calculates coinsurance based on the Plan's allowed amount. There is one exception. If a hospital provider's billed charges are less than the hospital's diagnosis related grouping (DRG) reimbursement, the Claims Administrator will calculate your coinsurance based on the lesser billed charges.

When you meet the applicable out-of-pocket maximum (see the applicable Cost-Share Summary at the end of this document), your coinsurance is 0% for the remainder of the calendar year.

Out-of-Pocket Maximum (Individual & Family)

An out-of-pocket maximum is the amount each member must pay each calendar year before the Plan begins paying 100% of the Plan's allowed amount for covered services, for the remainder of the calendar year. The payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

- amounts above a benefit limit or maximum
- any amounts for balance billing
- any amounts for noncovered services
- any charges for lack of precertification

Also, the out-of-pocket maximum doesn't affect any applicable copays. Rather, you must keep paying applicable copays even if you reach your out-of-pocket maximum. However, copays will count toward your reaching your out-of-pocket maximum.

If you have family coverage, there is also an out-of-pocket maximum for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members. An individual member cannot contribute more than his or her individual out-of-pocket maximum toward the family's out-of-pocket maximum.

If you're enrolled in Value or Core, there are separate in-network and out-of-network out-of-pocket maximums. This means you have to meet the in-network out-of-pocket maximum for in-network services and the out-of-network out-of-pocket maximum for out-of-network services. It also means in-network expenses don't count toward the out-of-network out-of-pocket maximum (and vice versa).

Precertification Charges

Certain benefits require preauthorization. If preauthorization is required but not obtained, the benefit may not be payable under the Plan or you might be subject to a precertification charge. Precertification charges reduce the amount payable by the Plan and do not count toward the calendar-year deductible or the out-of-pocket maximum. For more information about precertification requirements and precertification charges, see "Precertification Requirements" below and the **Description of Medical Benefits** section.

Balance Bill

A balance bill is generally an amount you may be charged for the difference between a noncontracted provider's billed charges and the Plan's allowed amount (see the **Medical Providers** section for more information about noncontracted providers). However, there might also be a balance bill in other situations, for example, when you receive services from an in-network provider which are in excess of a benefit limit or maximum.

If you are enrolled in Premium, then except for emergency services, and ancillary services provided in a network facility, noncontracted providers have no obligation to accept the Plan's allowed amount and you will be responsible for paying a noncontracted provider's billed charges and any amounts paid for balance bills do not count toward the deductible, coinsurance or out-of-pocket maximum.

If you are in Value or Core, then except for emergency services, and ancillary services provided in a network facility, noncontracted providers have no obligation to accept the Plan's allowed amount and you will be responsible for paying a noncontracted provider's billed charges, even though the Claims Administrator will reimburse your claims based on the Plan's allowed amount. Depending on what billing arrangements you make with a noncontracted provider, the provider may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that the Claims Administrator reimburses you on a claim. Any amounts paid for balance bills do not count toward the deductible, coinsurance or out-of-pocket maximum.

Precertification Requirements

When Is Precertification Required & What Happens If You Don't Obtain It

Not all services require precertification. Precertification is not required for emergency services or urgent care services. If it is required, your treating provider must obtain it on your behalf before providing services. Precertification may be required for services to be covered when provided in certain settings.

For more information on which services require precertification, see the **Description of Medical Benefits** section, visit azblue.com/individualsandfamilies/resources/forms and for medications that need to be precertified visit azblue.com/Pharmacy, or call the BCBSAZ customer service number on your ID card. Please note the Claims Administrator may change the services/medications that require precertification by posting a revised listing at www.azblue.com.

How to Obtain Precertification

Ask your provider to contact the Claims Administrator for precertification before you receive services and medications that require precertification. Your provider must contact the Claims Administrator because he or she has the information and medical records needed for the Claims Administrator to make a benefit decision. The Claims Administrator will rely on information supplied by your provider. If that information is inaccurate or incomplete it may affect the decision on your request or claim.

Factors Considered in Evaluating a Precertification Request

The following factors will generally be considered in evaluating a precertification request:

- applicability of other Plan provisions (e.g., limitations, exclusions and benefit maximums)
- whether the provider is in-network
- whether the service is medically necessary or experimental/investigational
- whether the service is provided in the appropriate care setting
- whether your coverage is active

Some of these factors may not be readily identifiable at the time of precertification, but will still apply if discovered later in the claim process and could result in denial of your claim.

If medication that is covered as a medical benefit under the Plan requires precertification, but you must obtain the medication outside of the Claims Administrator's precertification hours, you may have to pay the entire cost of the medication when it is dispensed. In such cases, you can file a reimbursement claim with the Claims Administrator and have your provider request precertification on the next business day. Your claim for the medication will not be denied for lack of precertification, but all other exclusions and limitations of the Plan will apply.

There are separate prior authorization requirements for prescription drugs covered under the prescription drug benefit (see "Prior Authorization" in the **Prescription Drug Benefit** section).

Precertification Approvals

If the Claims Administrator approves your or your provider's precertification request, you and your provider will receive a letter explaining the scope of precertification. However, precertification is not a pre-approval or a guarantee of payment. Any precertification made in error by the Claims Administrator is not a waiver of the Claims Administrator's right to deny payment for noncovered services or to seek recovery of an incorrect or over payment (see "Recovery of Incorrect & Over Payments" in the **Plan Administration** section).

Precertification Denials

If the Claims Administrator denies your or your provider's precertification request, the denial will be an adverse benefit decision. As explained in "Internal Claim Procedures" in the **Plan Administration** section, the Claims Administrator will send you and/or your provider a notice explaining the reason for the denial, and your right to appeal the denial.

If your or your provider's request is denied because the Claims Administrator decides the service is not medically necessary, remember that the Claims Administrator's interpretation of medical necessity is a benefits decision made in accordance with the provisions of the Plan. Your provider may recommend a service that is not covered under the Plan. You and your provider should decide whether to proceed with the noncovered service if the Claims Administrator denies precertification.

Medical Providers

The Plan gives you access to a network of providers in the United States that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield organization (collectively, referred to in this section as "BCBS"). Information about in-network providers is available at www.azblue.com or by calling the BCBSAZ customer service number on your ID card.

For services outside of the United States, you may be able to take advantage of the Blue Cross Blue Shield Global® Core program. If you have questions about this program, call the BCBSAZ customer service number on your ID card. If you're outside the United States and need medical assistance, you can call service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, 7 days a week.

Choosing a Provider

It's your choice what provider you use. However, one of the requirements for services to be covered is that the services are provided by an eligible provider (see the **Defined Terms** section). Also, if you're enrolled in Premium, you generally must use an in-network provider for services (which are otherwise covered) to be covered. If you're enrolled in Value or Core, you can choose to use an in-network provider or an out-of-network provider for most services, but your costs will be higher if you use an out-of-network provider.

Before receiving scheduled services, you should verify the network status of all providers who will be involved in your care, such as assistant surgeons, anesthesiologists, radiologists, and the facility where the services will be performed.

Your provider may recommend services that are not covered under the Plan. You and your provider should decide whether to proceed with a service that is not covered. Neither BCBS, the Plan Sponsor, the Participating Employers, the Plan Administrator, nor the Claims Administrator has any control over any diagnosis, treatment, care or other services provided by any provider (whether in- or out-of-network), and they disclaim any and all liability for any loss or injury to you caused by any provider by reason of the provider's negligence, failure to provide treatment, or otherwise.

In-Network Providers

In-network providers are providers who have contracted with BCBS to be in-network. They're independent contractors, not employees, agents or representatives of BCBS. Their contracts with BCBS address reimbursement and administrative policies. Each provider exercises independent medical judgment in deciding what services to provide you, and how to provide them.

In-network providers will typically file your claims with the Claims Administrator. The Claims Administrator directly reimburses in-network providers for the Plan's portion of the allowed amount for covered services, and you're responsible for paying your cost-share amount directly to the in-network provider. The Plan's allowed amount reflects any contractual arrangements negotiated with the provider, and contractual arrangements may vary based on many factors. For that reason, in-network providers may have varying compensation levels based on the providers' agreement to accept a certain reimbursement rate. This means your in-network cost-share for a particular service can vary depending on the in-network provider you use because not all providers have the same negotiated reimbursement rate for the same service. For more information, see the definition of "allowed amount" in the **Defined Terms** section.

In-network providers are generally prohibited by their contracts from charging you more than the Plan's allowed amount for covered services. However, when there is another source of payment, such as liability insurance, they may be entitled to collect their balance bill from the other source and may have medical lien rights under applicable law which are independent of the Plan or any contract with BCBS. Also, in-network contracts generally allow in-network providers to charge you for noncovered services and services in excess of a benefit limit or maximum, so you should discuss costs with your provider before you obtain noncovered services or services in excess of a benefit limit or maximum.

Out-of-Network Providers

Out-of-network providers are providers who have not contracted with BCBS to be in-network. Except for emergencies, services provided by out-of-network providers will be treated as out-of-network services and generally aren't covered if you're enrolled in Premium (see the exclusion for "Services Provided by Out-of-Network Providers" in the **General Exclusions** section, as well as the Premium Cost-Share Summary at the end of this document).

If you're eligible for out-of-network services, the costs for those services may vary depending on whether the out-of-network provider is a participating-only provider or a noncontracted provider. If you have questions about the status of an out-of-network provider, please call the BCBSAZ customer service number on your ID card.

Contracted (Participating-Only) Providers

A contracted (or participating-only) provider is a provider who has a contract with BCBS to be participating-only instead of in-network. These providers will generally submit your claim to the Claims Administrator. However, if you choose to pay the provider for a covered service on a direct pay basis, the provider generally will not submit your claim to the Claims Administrator. The Claims Administrator typically directly reimburses the provider for the Plan's portion of the allowed amount for covered service, and you're responsible for paying your cost-share amount directly to the provider. Except for emergency services and ancillary services provided in a network facility, if you receive covered services from a participating-only provider, you will not have to generally pay more than the Plan's allowed amount for covered services. For more information on how the Plan's allowed amount is determined, see the definition of "allowed amount" in the **Defined Terms** section.

Noncontracted Providers

A noncontracted provider is a provider who doesn't have a contract with BCBS. You're responsible for paying these providers and submitting the claims to the Claims Administrator if you believe benefits are payable under the Plan. If benefits are payable, the Claims Administrator will send payment to you (not the provider) for the Plan's portion of the allowed amount for covered services (see the definition of "allowed amount" in the **Defined Terms** section). Except for emergency services and ancillary services provided in a network facility, you're responsible for paying your cost-share amount as well as the balance bill. Since these providers may bill you up to their full billed charges (i.e., they aren't required to accept the Plan's allowed amount), the difference between what's payable under the Plan and what you're responsible for paying could be substantial. As a result, you should discuss costs with these providers before you obtain services from them.

Provider Status and Payment – Summary Table

Subject to all terms and conditions noted in this section.

Provider Contract Status	Network Status	Provider Required to File Claim on Member's Behalf	Accept BCBSAZ Allowed Amount and Do Not Balance Bill	Payee for Reimbursement
Providers contracted with the plan network	Network	Yes	Yes	BCBSAZ reimburses the provider the allowed amount, less any member cost share
Providers contracted with another Blue Cross or Blue Shield plan ("Host Blue") as	Network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost share

PPO providers				
Providers contracted with Host Blue as participating -only providers	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost share
Providers contracted with Blue Cross Blue Shield Global Core	Out-of-network	Yes	No	Blue Cross Blue Shield Global Core reimburses the provider the allowed amount less any member cost share
Noncontracted providers for non-emergency or non-ancillary services rendered in a network facility, in and outside Arizona, including providers who are contracted with BCBSAZ but not for your plan network (must be eligible providers)	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial.	BCBSAZ reimburses the member or the provider the allowed amount, less any member cost share.
Noncontracted emergency service providers—in and outside Arizona (must be	Out-of-network	No (provider may elect to do so as a courtesy to member)	Yes. If the provider disputes the allowed amount, the provider must resolve the dispute	BCBSAZ reimburses the member or the provider the allowed amount, minus your cost share.

eligible providers)

with BCBSAZ directly.

Special Circumstances

Services from an Out-of-Network Provider if No In-Network Provider

If you believe or have been told there's no in-network provider available to provide covered services you need, you may ask your provider to request precertification of in-network cost-share for your provider's services. The Claims Administrator will evaluate whether there is an in-network alternative. If the Claims Administrator determines an in-network provider is available to treat you, the Claims Administrator will not precertify in-network cost-share for your provider's services.

If the Claims Administrator precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. You'll still be responsible for any balance bill, plus your in-network cost-share.

If you're enrolled in Value or Core, this precertification process is separate from precertification of services that require precertification (see "Precertification" in the **Overview of Medical Benefits** section). This means, if you want an out-of-network provider to provide services that require precertification, and you also want to be eligible for the in-network cost-share, you must ensure your provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider.

Continuing Care from an Out-of-Network Provider

In certain limited cases, you may be able to receive benefits at the in-network level for services from an out-of-network provider for continuity of care. Generally, continuity of care will be approved only if:

- you have a life-threatening disease/condition or are in your third trimester of pregnancy,
- your treating provider is not an in-network provider because:
  - you're newly enrolled in the Plan, or
  - your provider's network status has changed, **and**
- your treating provider agrees to:
  - accept the Plan's allowed amount,
  - provide the Claims Administrator with any necessary medical information related to your care, and
  - accept and comply with the Plan's requirements (for example, the Plan's requirements regarding precertification and claims processing).

This continuity of care benefit is available only for providers, not facilities. If continuity of care is approved, all otherwise applicable terms of the Plan will apply. If you think you might be eligible for continuity of care and would like to request it, call the BCBSAZ customer service number on your ID card.

Description of Medical Benefits

This section explains covered services and benefit-specific maximums, limitations and exclusions. Please also refer to the **Medical Benefits Overview** section for general requirements for covered services and cost-share requirements, the **General Exclusions** section for general exclusions and limitations, and the applicable Cost-Share Summary at the end of this document for cost-share information for specific services. The Claims Administrator doesn't determine whether a service is covered under the Plan until after services are provided and the Claims Administrator receives a complete claim describing the services actually provided.

Acupuncture

***Precertification*:** Not required

***Benefit Description*:** Acupuncture services provided by an M.D., D.O., or a chiropractor who is a licensed acupuncturist.

Ambulance Services

***Precertification*:** Not required

***Benefit Description*:** All factors for coverage are determined by the Claims Administrator in its sole and absolute discretion. Benefits are available for:

- Air or water ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident, or acute illness occurs in an area inaccessible by ground vehicles, or transport by ground ambulance would be harmful to the member's medical condition
- Ground ambulance transportation from the site of an emergency, accident, or acute illness to the nearest facility capable of providing appropriate treatment
- Interfacility ground, water, or air ambulance transfer for admission to a facility when the transferring facility is unable to provide the level of service required

***Benefit-Specific Exclusions*:**

- Air ambulance transfers to any facility that is not an acute care facility, such as a skilled nursing facility or an extended active rehabilitation facility
- All other expenses for travel and transportation are not covered, except for the benefits described below in the Transplant or Gene Therapy Travel and Lodging benefit

Behavioral Health Services

(includes Treatment for Mental Health, Chemical Dependence, or Substance Abuse Disorders)

Note: These *Benefit-Specific Exclusions* apply to all behavioral and mental health services described below:

- Active therapy, milieu therapy and care primarily intended to assist an individual in the activities of daily care
- Biofeedback and hypnotherapy
- Custodial Care
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- Inpatient and outpatient facility charges for services provided for the following facilities:
  - Group homes
  - Wilderness programs
  - Boarding schools
  - Halfway houses
  - Assisted living centers
  - Shelters
  - Foster homes
- IQ testing
- Lifestyle and work-related education and training and management services
- Neurofeedback

- Sensory integration and music therapy
- Services provided after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by the Claims Administrator

Exception for Behavioral health services for minors that are otherwise covered under this section will not be denied solely on the basis that the services are provided in a school setting or are ordered by a court.

Inpatient Hospital

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Changing Types of Inpatient Care*:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient subacute and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you're moving to a level of care that requires precertification, you'll need to obtain a new precertification for the different level of care** (see "Precertification Requirements" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

***Benefit-Specific Exclusions*:**

- Domiciliary Care
- Medications dispensed at the time of discharge from an inpatient facility
- Private Duty Nursing
- Respite Care
- The benefit-specific exclusions listed above at the beginning of this Behavioral and Mental Health Services benefit

Inpatient Subacute Hospitalization – Behavioral Health Facility Services

***Precertification*:** Required, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Changing Types of Inpatient Care*:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient subacute and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you're moving to a level of care that requires precertification, you'll need to obtain a new precertification for the different level of care** (see "Precertification Requirements" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for:

- Diagnostic testing
- Medications, biologicals and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

Benefits are available for inpatient behavioral and mental health services that meet **all** the following criteria:

- The facility is licensed to provide behavioral health services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for physical health services provided at the facility
- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times
- The facility's designated clinical director is a behavioral health professional and provides direction for the behavioral health services provided at the facility
- The facility has 24/7 onsite registered nursing coverage
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment **and**
- The services meet the Claims Administrator's medical necessity criteria for inpatient level of care

***Benefit-Specific Exclusions*:**

- Domiciliary Care
- Medications dispensed at the time of discharge from an inpatient facility
- Private Duty Nursing
- Respite Care
- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- The benefit-specific exclusions listed above at the beginning of this Behavioral and Mental Health Services benefit

Behavioral and Mental Health Services (Outpatient Facility and Professional Services)

***Precertification*:** Not required

***Benefit Description*:** Non-emergency outpatient behavioral health services are available. Those services include psychotherapy, outpatient therapy for chemical dependency or substance use disorder, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT) and partial hospitalization.

***Benefit-Specific Exclusions*:** The benefit-specific exclusions listed above at the beginning of this Behavioral and Mental Health Services benefit.

Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder

***Precertification*:** Not required

***Benefit-Specific Definitions*:**

- "Autism Spectrum Disorder" means Autistic Disorder, Asperger's Syndrome, or Pervasive Developmental Disorder (not otherwise specified), as defined in current evidence-based criteria and referenced in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- "Behavioral Therapy" means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

***Benefit Description*:** Behavioral therapy services for the testing and treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law.

***Benefit-Specific Exclusions*:** The benefit-specific exclusions listed above at the beginning of this Behavioral and Mental Health Services benefit.

Cardiac and Pulmonary Rehabilitation – Outpatient Services

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for outpatient Phase I and II cardiac rehabilitation programs and pulmonary rehabilitation services.

Cataract Surgery and Keratoconus

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of external contact lenses or eyeglasses post-cataract surgery and for the first pair of contact lenses for treatment of keratoconus.

***Benefit-Specific Exclusion*:** Procedures associated with cataract surgery that are not included in the benefit description, including replacement, piggyback or secondary intraocular lenses and any other treatments or devices for refractive correction.

Chiropractic Services

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for chiropractic services.

***Benefit-Specific Exclusions*:** Maintenance or preventive treatment consisting of routine, long-term, or non-medically necessary care provided to prevent reoccurrences or to maintain the patient’s current status.

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Clinical Trials

***Precertification*:** Not required, but please notify the Claims Administrator if you're enrolled in a clinical trial to help them correctly process your claims for covered services associated with the clinical trial.

Benefit-Specific Definition*:* **"**Approved Clinical Trial" means a Phase 1, 2, 3, or 4 clinical trial conducted for the prevention, detection, or treatment of cancer or other life-threatening disease or condition and also approved or funded by at least one of the following:

- • A panel of qualified, recognized clinical research experts within an Arizona academic health institution
- • Food and Drug Administration (FDA) reviewed investigational new drug application
- • The National Institutes of Health (NIH), including a NIH health cooperative group or center or a qualified research entity that meets the criteria established by NIH for grant eligibility
- • The U.S. Department of Defense
- • The U.S. Department of Veterans Affairs

Benefit Description**:** Benefits are available for covered services directly associated with an Approved Clinical Trial meeting all requirements specified by applicable federal and Arizona law. Benefits are limited to those services coverage under the Plan that would be required if you received standard, non-investigational treatment. If you have any questions about whether a particular service will be covered, please call the BCBSAZ customer service number on your ID card. You or your provider must inform the Claims Administrator that you're enrolled in a clinical trial, that the trial meets the requirements to be an Approved Clinical Trial, and that the services to be provided are directly associated with the trial. Otherwise, the Claims Administrator will administer your benefits according to the other terms of the Plan, which may result in a denial of benefits.

Benefit-Specific Exclusions**:**

- Investigational medications and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Costs and services customarily paid for by government, biotechnical, pharmaceutical and device industry sources
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under the Plan

Dental Services Benefit – Medical

Note**:** Not all dentists who are contracted with BCBS are contracted to provide medical-related dental services. If you have questions, call the BCBSAZ customer service number on your ID card.

Dental Accident Services

Precertification**:** Not required

Benefit-Specific Definitions**:**

- "Accidental dental injury" means an accidental injury to the structures of the teeth that is caused by an external force or element such as a blow or fall. An injury to a tooth while chewing is not considered an accidental dental injury, even if the injury is due to chewing on a foreign object.
- "Sound teeth" means teeth that are:
  - Whole or virgin **or**
  - Restored with amalgam (silver filling) or composite resin (tooth-colored filling) or restored by cast metal, ceramic/resin-to-metal or laboratory processed resin/porcelain restorations (crowns) **and**
  - Without current periodontal (tissue supporting the tooth) disease or current endodontal (tooth pulp or root) disease **and**

- Not in need of the treatment provided for any reason other than as the result of an accidental dental injury

***Benefit Description*:** Benefits are available only for the following services to repair or replace sound teeth damaged or lost by an accidental dental injury:

- Extraction of teeth damaged as a result of accidental dental injury
- Original placement of fixed or removable complete or partial dentures
- Original placement, repair or replacement of crowns
- Original placement, repair or replacement of veneers
- Orthodontic services directly related to a covered accidental dental injury

***Benefit-Specific Exclusions*:**

- Gold foil restorations or inlays
- Occlusal rehabilitation and reconstruction
- Original placement, repair or replacement of dental implants and any related services
- Repair and replacement of fixed or removable complete or partial dentures
- Routine dental care
- Routine extractions

Dental Services Required for Medical Procedures

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for dental services required to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure:

- Diagnostic services prior to planned organ or stem cell transplant procedures
- Removal of teeth required for covered treatment of head and neck cancer or osteomyelitis of the jaw
- Restoration of teeth made medically necessary because of the covered treatment of head and neck cancer or osteomyelitis of the jaw

***Benefit-Specific Exclusions*:**

- Dental implants and any related services
- Gold foil restorations and inlays
- Occlusal rehabilitation and reconstruction
- Orthodontic services
- Routine dental care
- Routine extractions
- Repair and replacement of fixed or removable complete or partial dentures

Medical Services Required for Dental Procedures (Facility and Professional Anesthesia Charges)

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a

precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for facility and professional anesthesiologist charges incurred to perform dental services under anesthesia in an inpatient or outpatient facility for a patient having one or more of the following concurrent or co-morbid conditions:

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Malignant hypertension
- Mental retardation
- Senility or dementia
- Unstable cardiovascular condition
- Uncontrolled seizure disorder
- Diabetes
- Hemophilia
- Probability of allergic reaction
- Heart problems
- Dental extractions due to cancer related conditions
- Other conditions that could increase the danger of anesthesia
- Other conditions (if any) for which these services are required by applicable law to be covered

Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics

Note: *Benefit-specific maximum* of one (1) breast pump and breast pump supplies per member, per calendar year. This limit does not apply to claims submitted with a primary behavioral health diagnosis. **These *benefit-specific exclusions* apply to all durable medical equipment, medical supplies and prosthetic appliances and orthotics described below:**

- Biomechanical devices, which are any external devices operated through or in conjunction with nerve conduction or other electrical impulses
- Certain equipment and supplies that can be purchased over-the-counter, as determined by the Claims Administrator. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings, except TED hose, elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas and vehicle or home modifications.
- Hair transplants
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience or other nonmedical reasons
- Out-of-network items
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments

- Tilt or inversion tables or suspension devices
- Wigs and hair pieces for alopecia caused by anything other than chemotherapy, radiation therapy, second or third degree burns or a behavioral health diagnosis

Durable Medical Equipment (DME)

***Precertification*:** Not required

***Benefit Description*:** To be eligible for coverage, DME must meet **all** of the following criteria:

- Be designed for appropriate medical use in the home setting
- Be specifically designed to improve or support the function of a body part and

Cannot be primarily useful to a person in the absence of an illness or injury Benefits are available for DME rental or purchase, as determined by the Claims Administrator, and for DME repair or replacement, as determined by the Claims Administrator, due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. **Benefits are limited to the allowed amount for the DME item base model.** The Claims Administrator determines what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon the Claims Administrator's medical necessity criteria.

***Benefit-Specific Exclusions*:**

- Charges for continued rental of a DME item after the allowed amount is reached
- Repair costs that exceed the allowed amount of the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications
- The benefit-specific exclusions listed above at the beginning of this Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics benefit

Medical Supplies

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for the following medical supplies:

- Any device or supply required by applicable law or as otherwise permitted under current evidence-based criteria
- Blood glucose monitors
- Blood glucose monitors, including monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices (including drawing-up devices for the visually impaired)
- Diabetic syringes and lancets, including automatic lancing devices
- Insulin cartridges, including insulin cartridges for the legally blind
- Insulin preparations and glucagon
- Insulin pumps and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Prescribed oral agents for controlling blood sugar that are included under the Plan
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and visual reading and urine test strips
- Volume nebulizers
- Other medical supplies (if any) required by applicable law to be covered

Benefits are limited to the allowed amount for the medical supply base model. The Claims Administrator determines what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon the Claims Administrator's medical necessity criteria.

***Benefit-Specific Exclusions*:** The benefit-specific exclusions listed above at the beginning of this Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics benefit.

Prosthetic Appliances and Orthotics

Benefit-Specific Definitions:

- "Depth shoes" means the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; is made of leather or other suitable material of equal quality; has some sort of shoe closure; and is available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.
- "Custom-molded shoes" means the shoe is constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; has removable inserts that can be altered or replaced as the member's condition warrants; and has some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for the following:

- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- External and internal prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the support or function of a body part or for the alleviation or correction of illness, injury, or congenital defect. External prosthetic appliances include artificial arms and legs, wigs, hairpieces, and terminal devices such as a hand or hook. Wigs and hairpieces are covered for members who are diagnosed with:
  - Alopecia (absence of hair) caused by chemotherapy, radiation therapy, or second- or third-degree burns
  - A behavioral health condition, **and**
  - Other condition (if any) for which coverage is required by applicable law
- Orthopedic shoes that are:
  - Attached to a brace
  - Shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes **and**
  - Covered in accordance with the Claims Administrator's medical necessity criteria
- Podiatric appliances for prevention of complications associated with diabetes, including foot orthotic devices and inserts. Therapeutic shoes, including depth shoes or custom-molded shoes, as defined above. Custom-molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications of diabetes involving the foot: peripheral neuropathy with evidence of callus formation; history of pre-ulcerative calluses; history of previous ulceration; foot deformity; previous amputation of the foot or part of the foot; or poor circulation.
- Other prosthetic appliances and orthotics (if any) required by applicable law to be covered

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. The Claims Administrator determines what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon the Claims Administrator's medical necessity criteria.

***Benefit-Specific Exclusions*:** The benefit-specific exclusions listed above at the beginning of this Durable Medical Equipment (DME), Medical Supplies and Prosthetic Appliances and Orthotics benefit.

Education and Training

Diabetes and Asthma Education and Training

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for diabetes and asthma education and training from providers whose services are:

- Provided in an outpatient setting (outpatient hospital, physician office or other provider, excluding home health)
- Conducted in person **and**
- Prescribed by a patient's health care provider as part of a comprehensive plan of care to enhance therapy compliance and improve self-management skills and knowledge for a patient diagnosed with diabetes or asthma

Nutritional Counseling and Training

***Precertification*:** Not required

***Benefit Description*:** Nutritional counseling and training is available for members diagnosed with one or more of the following conditions:

- Behavioral health
- Cardiovascular Disease
- Coronary Artery Disease
- Diabetes
- Eating Disorders
- Food Allergies
- Gastrointestinal Disorders
- Heart Failure
- High Cholesterol
- Hypertension
-
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

***Benefit-Specific Maximum*:** Benefits are limited to six (6) nutritional counseling and training visits per member, per calendar year.

Emergency (Professional and Facility Charges)

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for services needed to treat an emergency medical condition.

Eosinophilic Gastrointestinal Disorder

***Precertification*:** Not required

***Benefit-Specific Definitions*:**

- "Cost" means billed charges if the formula is purchased from an out-of-network provider or the allowed amount if the formula is purchased from an in-network-provider.
- "Formula" means an amino-acid based formula.

***Benefit Description*:** Benefits are available for Formula for members who are:

- At risk of mental or physical impairment if deprived of the Formula
- Diagnosed with eosinophilic gastrointestinal disorder **and**
- Under the continuous supervision of a physician or a registered nurse practitioner

Family Planning (Contraceptives and Sterilization)

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for FDA-approved contraceptive methods, devices and sterilization procedures when prescribed by the member's provider.

***Benefit-Specific Exclusion*:** All prescription and over-the-counter contraceptive medications and devices for male members.

Hearing Aids and Services

***Precertification*:** Not required

Benefit Description*:** Benefits are available for routine hearing exams (except hearing screenings performed as part of a routine well exam) Hearing Aids, new or replacement Hearing Aids no longer under warranty, cleaning and repair of Hearing Aids, and dispensing fees for Hearing AidsBenefit-Specific Maximum*:** There is a maximum benefit of one (1) hearing aid per member, per hearing impaired ear, per two (2) years. This limit does not apply to claims for claims submitted with a primary behavioral health diagnosis.

***Benefit Specific Exclusions*:**

- Assistive listening devices, including but not limited to, hearing aids that sync wirelessly with MP3 players, laptops, televisions and/or other wireless devices
- Disposable hearing aids
- Batteries or battery replacement for hearing aids other than cochlear implants
- Additional warranties for hearing aids
- Replacement of lost, stolen or damaged hearing aids when the member has already reached the benefit maximum of one (1) hearing aid per member, per ear, per 24-month period
- Earmolds
- Direct audio input, Bluetooth capability or other additional features
- Return or exchange fees for hearing aids that are returned or exchanged
- Follow-up visits in addition to the original hearing exam

Home Health Services

***Precertification*:** Required for certain medications covered under this benefit. Go to www.azblue.com for a listing of medications that require precertification or call the BCBSAZ customer service number on your ID Card. **If you don't obtain precertification for these medications, they will not be covered.**

***Benefit-Specific Definition*:** "Sole source of nutrition" means the inability to orally receive more than 30% of daily caloric needs.

***Benefit Description*:** Benefits are available for the following services:

- Enteral nutrition (tube feeding) when it is the sole source of nutrition
- Home infusion medication administration therapy, including:
  - Blood and blood components
  - Hydration therapy
  - Intravenous catheter care
  - Intravenous, intramuscular or subcutaneous administration of medication
  - Total parenteral nutrition
- Physical therapy, occupational therapy, and speech therapy
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition, and other services that require skilled nursing care
- Other home health services (if any) required by applicable law to be covered

Each service must meet **all** of the following criteria:

- A health care provider must order the service pursuant to a specific plan of home treatment
- A licensed home health agency must provide the service in the member's residence
- The health care provider must review the appropriateness of the service at least once every 30 days or more frequently, if appropriate under the treatment plan **and**
- The service must be provided by an LPN, RN, or another eligible provider

***Benefit-Specific Maximum*:** Benefits are limited to any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition and/or other services requiring skilled nursing care, up to a maximum of 120 visits (combined in- and out-of-network if you're enrolled in Value or Core) per member, per calendar year. The home health visit limit doesn't apply to home health services provided in lieu of hospitalization or hospital outpatient services, or to claims for home health services submitted with a primary behavioral health diagnosis.

***Benefit-Specific Exclusions*:**

- All services in excess of the 120 visit per calendar year maximum, except as stated in this section
- Custodial Care
- Private Duty Nursing
- Respite Care
- Domiciliary Care

Hospice Services

***Precertification*:** Not required

***Changing Types of Inpatient Care*:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). If you move or transfer between

different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you're moving to a level of care that requires precertification, you'll need to obtain a new precertification for the different level of care** (see "Precertification Requirements" in the **Medical Benefits Overview** section).

***Benefit-Specific Definition*:** "Hospice services" mean an alternative multi-disciplinary approach to medical care for the terminally ill. No curative or aggressive treatments are used.

***Benefit Description*:** When a member elects to use the Hospice Services benefit, it is in lieu of other medical benefits available under the Plan, except for care unrelated to the terminal illness or related complications.

The hospice agency determines the required level of care, which is subject to the Plan's medical necessity provisions. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's health care needs related to the terminal illness.

The member's physician must certify that the member is in the later stages of a terminal illness and prescribe hospice care, which must be provided by a state-licensed hospice agency. The member must meet the requirements of the hospice.

Benefits are available for the following services:

- *Continuous Home Care*: 24-hour skilled care provided by an R.N. or L.P.N. during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- Home health services
- Individual and family counseling provided by a psychologist, social worker, or family counselor
- *Inpatient Acute Care*: Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- Outpatient services
- *Respite Care*: Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- *Routine Care*: Intermittent visits provided by a member of the hospice team

Infertility Services

***Precertification*:** Not required

***Benefit Description*:** Benefits are available s to treat infertility including:

- Artificial insemination
- In-vitro fertilization
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)

***Benefit-Specific Maximum*:** There is a $15,000 per member benefit maximum for services to treat infertility.

Inpatient and Outpatient Detoxification Services

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a

precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit-Specific Definition*:** "Detoxification services" mean the initial medical treatment and support provided to a chemically dependent or addicted individual during acute withdrawal from a drug or substance.

***Benefit Description*:** Benefits are available for medical observation and detoxification services needed to stabilize a member who has developed substance intoxication due to the ingestion, inhalation or exposure to one or more substances.

Inpatient Hospital

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Changing Types of Inpatient Care*:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient rehabilitation and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you're moving to a level of care that requires precertification, you'll need to obtain a new precertification for the different level of care** (see "Precertification Requirements" in the **Medical Benefits Overview** section).

***Benefit Description*:**

- Adjustments to bariatric surgery provided while the member was covered under another plan
- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- General, spinal and caudal anesthetic provided in connection with a covered service
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Operating, recovery and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy, except in conjunction with a noncovered transplant
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Other inpatient services (if any) required by applicable law to be covered

***Benefit-Specific Exclusions*:**

- Bariatric surgeries received from out-of-network facilities or providers
- Medications dispensed at the time of discharge from a hospital

Inpatient Rehabilitation – Extended Active Rehabilitation (EAR) Services

***Precertification*:** Required, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for an EAR admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Changing Types of Inpatient Care*:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you're moving to a level of care that requires precertification, you'll need to obtain a new precertification for the different level of care** (see "Precertification Requirements" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for an intense therapy program which is provided in a facility licensed to provide EAR services and which meets **all** of the following criteria:

- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times
- Services must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time
- The facility has 24/7 onsite RN coverage
- The facility has sufficient professional staff to provide appropriate treatment
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for services provided at the facility **and**
- The services meet the Claims Administrator's medical necessity criteria for inpatient level of care

Room and board is only covered in a semi-private room (or in a standard private room (not deluxe) but only if the hospital only has private rooms or a private room is medically necessary).

***Benefit-Specific Exclusions*:**

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Domiciliary Care
- Medications dispensed at the time of discharge from a facility
- Private Duty Nursing
- Respite Care
- Services provided after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by the Claims Administrator

Long-Term Acute Care (Inpatient)

***Precertification*:** Required, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a long-term acute care admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Changing Types of Inpatient Care*:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you're moving to a level of care that requires precertification, you'll need to obtain a new precertification for the different level of care** (see "Precertification Requirements" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide long-term acute care and which offers specialized treatment programs and aggressive clinical and therapeutic interventions. Room and board is only covered in a semi-private room (or in a standard private room (not deluxe) but only if the hospital only has private rooms or a private room is medically necessary).

***Benefit-Specific Maximum*:** Benefits are limited to three hundred sixty-five (365) days of long-term acute care services (combined in- and out-of-network if you're enrolled in Value or Core) per member. This limit does not apply to claims for long-term acute care services submitted with a primary behavioral health diagnosis. If you have questions about the benefit maximum, contact the BCBSAZ customer service number on your ID card.

***Benefit-Specific Exclusions*:**

- Custodial Care
- Domiciliary Care
- Private Duty Nursing
- Medications dispensed at the time of discharge from the facility
- Respite Care

Maternity

***Precertification*:** Not required

***Benefit-Specific Definition*: "**Global Charge" means a fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

***Benefit Description*:** Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others, as determined by the Claims Administrator. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call the BCBSAZ customer service number on your ID card.

Covered maternity services are available from birthing centers. Professional services provided in the member's home must be provided by an eligible provider, and your cost-share may vary depending on the type of provider and the provider's network status.

Your cost-share is waived for maternity services covered under the Preventive Services benefit and delivered by an in-network provider.

Your cost-share obligations may be affected by the addition of a newborn or adopted child. For example, if you have coverage only for yourself and no dependents, the addition of a child will result in a change from employee-only coverage to family coverage. In that case, you'll be required to meet a family deductible and out-of-pocket maximum. You'll also have to pay an additional premium amount for your dependent's coverage.

Maternity benefits are available for the expense incurred by a birth mother (who is not a member) for the birth of any child legally adopted by a member, if **all** of the following requirements are met:

- The member adopts the child within one year of birth
- The member is legally obligated to pay the costs of birth **and**
- The member has provided notice to the Claims Administrator within sixty (60) days of the member's acceptability to adopt children

This adopted child Maternity benefit is secondary to any other coverage available to the birth mother. For the Claims Administrator's adoption packet, call the BCBSAZ customer service number on your ID card.

***Statement of Your Rights Under the Newborns' and Mothers' Health Protection Act*:** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours for the monther and newborn child following a normal vaginal delivery or 96 hours for the mother and newborn child following a cesarean section delivery. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, see "Precertification Requirements" in the **Medical Benefits Overview** section and/or call the BCBSAZ customer service number on your ID card.

Medical Foods for Inherited Metabolic Disorders

Note: Medical Foods may also be covered under the Home Health Services benefit.

***Precertification*:** Not required

***Benefit-Specific Definitions*:**

- "Cost" means billed charges if the member buys the Medical Foods from an out-of-network provider or the allowed amount if the member buys the Medical Foods from an in-network provider.
- "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry that meets **all** of the following requirements:
  - The disorder is one of the diseases tested under the newborn screening program required under Arizona law (A.R.S. § 36-694)
  - The disorder is such that an afflicted individual will need to consume Medical Foods throughout life in order to avoid serious mental or physical impairment **and**
  - The disorder involves amino acid, carbohydrate or fat metabolism and has medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues, as determined by the Claims Administrator
- "Medical Foods" means modified low protein foods and metabolic formulas that are **all** of the following:
  - Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation
  - Essential to the member's optimal growth, health and metabolic homeostasis
  - Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an M.D. or D.O. physician or a registered nurse practitioner

- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only) **and**
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only)

***Benefit Description*:** Benefits are available for Medical Foods to treat Inherited Metabolic Disorders.

***Benefit-Specific Exclusions*:**

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an M.D. or D.O. physician or a registered nurse practitioner
- Food thickeners, baby food or other regular grocery products
- Medical foods and formulas for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end stage disease etc.
- Spices and flavorings
- Standard oral infant formula

***Claims for Reimbursement*:** You may buy Medical Foods from any source (i.e., an in-network provider or an out-of-network provider), even if you're enrolled in Premium. If you buy Medical Foods from an out-of-network provider, you must submit a claim form with **all** of the following information:

- Member's diagnosis for which the Medical Foods were prescribed or ordered
- Member's name, identification number, group number and birth date
- Prescribing or ordering physician or registered nurse practitioner
- The amount paid for the Medical Foods
- The dated receipt or other proof of purchase **and**
- The name, telephone number and address of the Medical Food supplier

Medical Foods claim forms are available from the Claims Administrator. Submit the completed Medical Foods Claim Form and the dated receipt to the Claims Administrator (see "Claim Forms & Where to File Claims " under "Internal Claim Procedures" in the **Plan Administration** section).

Neuropsychological and Cognitive Testing

***Precertification*:** Not required

***Benefit Description*:** Services are available for the evaluation of decreased mental function or developmental delay.

Outpatient Services

***Precertification*:** Required for certain cellular immunotherapies, gene therapies, genetic testing, high tech radiology, medical oncology, radiation oncology, and medications regardless of where they are administered. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for outpatient services that require precertification, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section). **If you don't obtain precertification for medications that require precertification, the medications will not be covered.**

***Benefit Description*:** Benefits are available for the following outpatient services and include, but are not limited to, any services that would be covered if performed as an inpatient service:

- Adjustments to bariatric surgery provided while the member was covered under another plan
- Allergy testing, antigen administration, and desensitization treatment
- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Dialysis
- End-stage renal disease services
- Epidural and facet injections and radio frequency ablation for pain management
- Infusion/IV therapy in an outpatient setting
- In-network benefits are available for covered cellular immunotherapies and gene therapies only when administered in a contracted Blue Distinction Center
- Maternity services provided in birthing centers
- Medications, and the administration of medications, in an outpatient setting
- Orthognathic treatment and surgery, including but not limited to dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), and video EEG
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures
- Treatment of Temporomandibular Joint Disorders (TMJ)

***Benefit-Specific Exclusion*:** Bariatric surgeries received from out-of-network facilities or providers.

Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) Services

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for PT, OT, and ST services.

***Benefit-Specific Maximum*:** Benefits are limited to a maximum of sixty (60) combined PT, OT, and ST visits (combined in- and out-of-network if you're enrolled in Value or Core) per member, per calendar year. If you are enrolled in Value or Core, this limit does not apply to claims submitted with a primary behavioral health diagnosis or to claims associated with a diagnosis of Autism. If you are enrolled in EPO, the limit does not apply to claims submitted with a primary behavioral health diagnosis or to claims associated with a diagnosis of Autism. Evaluations are also not included in this limit.

Benefit-Specific Definitions:
"Occupational Therapy" is treatment of neuromusculoskeletal dysfunction (injuries or disorders of the musculoskeletal system, such as muscles, tendons, ligaments, nerves, discs, and blood vessels) using specific tasks or goal-directed activities to improve functional performance.

"Physical Therapy" is treatment of disease or injury using therapeutic exercise and other measures to improve posture, locomotion, strength, endurance, balance, coordination, range of motion, flexibility, and ability to perform activities of daily living, and to help reduce pain.

"Speech Therapy" is treatment of communication impairment and swallowing disorders.
Benefit Description: Benefits are available for PT, OT, and ST services related to a specific illness or injury.

***Benefit-Specific Exclusions*:**

- Activity therapy and milieu therapy including community immersion or integration and home independence
- Any care for comfort and convenience
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Domiciliary Care
- Massage therapy, except in limited circumstances as described in current evidence-based criteria
- Occupational therapy for any purpose other than training the member to perform the activities of daily living
- Phase III cardiac rehabilitation programs
- Physical or occupational therapeutic services performed in a group setting of two (2) or more individuals
- Services provided after a member has met functional goals
- Services provided when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength
- Work re-entry therapy, services or programs

Physician Services

***Precertification*:** Required for certain cellular immunotherapies, gene therapies, and medications (collectively, "medications") regardless of where they are administered, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for medications for which precertification is required, you'll be responsible for a pre-certification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section). Go to www.azblue.com for a listing of medications that require precertification or call the BCBSAZ customer service number on your ID Card.

***Benefit Description*:** Benefits are available for the following:

- Abortifacient medications for the abortions covered under the Plan, including oral medications as described in current evidence-based criteria
- Allergy testing, antigen administration, and desensitization treatment
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics) for the diagnosis and treatment of a sickness or injury
- Orthognathic treatment and surgery
- Inpatient medical visits
- Medications and the administration of medications in a physician's office
- Second diagnostic surgical opinions
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides; and FDA-approved emergency contraception.
- Services for FDA-approved female sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices

- Services for FDA-approved female implanted contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery). Call the BCBSAZ customer service number on your ID card to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Treatment of TMJ

The following circumstances may impact a member's cost-share for physician services:

- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted providers may bill the full amount for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.
- You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If the other provider submits a separate claim for those services or supplies, you will pay the cost-share for the other provider plus the cost-share for your office visit. Examples of services or supplies from another provider include durable medical equipment from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

Post-Mastectomy Services

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available, to the extent required by applicable law, for breast reconstruction following a medically necessary mastectomy. Benefits include:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, including postoperative implanted or external prostheses
- Treatment of physical complications for all stages of the mastectomy, including lymphedema.

Notice of Your Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA)*:** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving the mastectomy-related benefits described above in the ***Benefit Description, coverage will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost-share generally applicable to other medical and surgical benefits provided under the Plan (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section). If you would like more information on WHCRA benefits, call the BCBSAZ customer service number listed on your ID card.

Pregnancy, Termination

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for elective and non-elective abortions. Benefits are also available for abortifacient medications for the abortions covered under the Plan, including some oral medications, as described in current evidence based criteria.

Preventive Services

Note: Services or tests listed in this Preventive Services benefit but provided to a member with a specific diagnosis, signs or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of the Plan. Certain maternity services covered under this Preventive Services benefit are also available through the Maternity benefit.

***Precertification*:** Not required

***Benefit-Specific Definition*:** "Preventive Services" means those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive Services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

***Benefit Description*:** Benefits are available for the following services recommended by your provider and as appropriate for the member's age and gender, and as recommended by:

- Advisory Committee on Immunization Practices (ACIP) routine immunization recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html
- Health Resources and Services Administration (HRSA) guidelines for pediatric and adolescent preventive care and screening at https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html
- HRSA guidelines for women's health care services at www.hrsa.gov/womens-guidelines/index.html
- U.S. Preventive Services Task Force (USPSTF) A or B rated services at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

Benefits are also specifically available for the following services:

- Mammograms for routine breast cancer screening, including:
  - A single baseline mammogram for members ages 35-39 and
  - One mammogram per year for members age 40 and older or
  - More frequent mammograms based on the physician’s recommendation
- Prostate specific antigen (PSA) testing and digital rectal examination (DRE) for members age 40 and older, or for members under age 40 who are at high risk due to:
  - Family history (such as multiple first-degree relatives diagnosed at an early age)
  - African-American race or
  - Previous borderline PSA levels
- Well-baby/child care up to 47 months and childhood immunizations

Benefits will be provided for any other Preventive Service required by applicable law. For questions about Preventive Services covered under this benefit, call the BCBSAZ customer service number on your ID card.

If a Preventive Service has been denied due to your gender on file with the Claims Administrator, and you're undergoing or have undergone a gender transition, please call the BCBSAZ customer service number on your ID card for assistance. The Plan covers all gender-specific Preventive Services that are deemed medically necessary for a member, as determined by the member's attending provider, without regard to the member's gender identity, gender assigned at birth, or gender that is on file with the Claims Administrator.

***Benefit-Specific Maximum*:** Benefits are limited to one (1) manual or electric (not hospital grade) breast pump and breast pump supplies per member, per calendar year. This limit doesn't apply to claims for Preventive Services submitted with a primary behavioral health diagnosis.

***Benefit-Specific Exclusions*:**

- Abortifacient medications (but these medications may be covered under the Physician Services benefit or Pregnancy, Termination benefit)
- All prescription and over-the-counter contraceptive medications and devices for male members

Reconstructive Surgery and Services

***Precertification*:** Required for non-emergency inpatient admissions, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a non-emergency admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for reconstructive surgery, which is a surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects
- Illness and disease
- Injury and trauma
- Surgery
- Therapeutic intervention

***Benefit-Specific Exclusion*:** Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations and other services for cosmetic purposes. This exclusion does not apply to:

- Breast reconstruction following a medically necessary mastectomy, to the extent required to be covered by applicable law
- Medically necessary breast implant removal
- Other services (if any) required by applicable law to be covered

Skilled Nursing Facility (SNF) Services

***Precertification*:** Required, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification for a SNF admission, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Changing Types of Inpatient Care*:** Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, inpatient rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you're moving to a level of care that requires precertification, you'll need to obtain a new precertification for the different level of care** (see "Precertification Requirements" in the **Medical Benefits Overview** section).

***Benefit Description*:** Benefits are available for inpatient skilled nursing facility services which are provided in a facility licensed to offer 24-hour skilled nursing services and which meet **all** of the following criteria:

- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times

- Services must be provided to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time
- Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as an LPN or RN, and provided at a level of complexity and sophistication requiring assessment, observation, monitoring, and/or teaching or training to achieve the medically desired outcome
- The facility has 24/7 onsite RN coverage
- The facility has sufficient professional staff to provide appropriate treatment
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for services provided at the facility **and**
- The services meet the Claims Administrator's medical necessity criteria for inpatient level of care

Room and board is only covered in a semi-private room (or in a standard private room (not deluxe) but only if the hospital only has private rooms or a private room is medically necessary).

***Benefit-Specific Maximum*:** Benefits are limited to one hundred twenty (120) days of SNF services (combined in- and out-of-network if you're enrolled in Value or Core) per member, per calendar year. This limit does not apply to claims for SNF services submitted with a primary behavioral health diagnosis.

***Benefit-Specific Exclusions*:**

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Domiciliary Care
- Medications dispensed at the time of discharge from a facility
- Private Duty Nursing
- Respite Care
- Services provided after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by the Claims Administrator

Telehealth Services – BlueCare Anywhere

***Precertification*:** Not required

***Benefit Description*:** Remote medical and behavioral health consultations between a provider and a patient are offered by the Telehealth Services Administrator (TSA) through BlueCare Anywhere, including:

- Medical Consultations with a physician, physician's assistant, or nurse practitioner
- Counseling with a psychologist or other licensed therapist
- Psychiatry Consultations with a psychiatrist

To use BlueCare Anywhere, contact the TSA (see "Help With Your Benefits" in the **Understanding Your Plan** section). After you connect with a provider, if he or she determines that your condition is not appropriate for Telehealth Services, the provider will suggest that you seek in-person treatment.

***Benefit-Specific Exclusions*:**

- Emergency services
- Preventive services
- Services covered under the Telehealth Services benefit
- Services not provided through the Telehealth Services Administrator

Teleheatlh Services

***Precertification*:** Not required

***Benefit Description*:** Benefits are available for Telehealth Services delivered by an in-network provider through interactive electronic media to treat the following conditions:

- Burns
- Cardiologic conditions
- Dermatologic conditions
- Infectious diseases
- Mental health disorders
- Neurologic diseases, including strokes
- Pain medicine
- Pulmonary diseases
- Substance abuse
- Trauma
- Urology
- Other conditions (if any) for which coverage is required by applicable law

Benefits are also available for emergency or urgent Telemedicine Services from out-of-network providers to treat one of the above covered conditions.

***Benefit-Specific Exclusions*:**

- Non-emergency and non-urgent Telehealth Services from an out-of-network provider
- Services delivered through the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail unless otherwise required by law
- Services provided through the Telehealth Services – BlueCare Anywhere benefit
- Telemedicine Services for diseases or disorders not listed above

Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures

***Precertification*:** Required prior to any organ, tissue or bone marrow transplant or stem cell procedure, but you will not be penalized if your in-network provider fails to obtain precertification. If you're eligible for out-of-network services but your out-of-network provider fails to obtain precertification, you'll be responsible for a precertification charge of $500 (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

***Benefit-Specific Definition*: "**Bone Marrow Transplant" means a medical or surgical procedure comprised of several stages, including administration of high dose chemotherapy and high dose radiotherapy as prescribed by the treating physician; harvesting of stem cells from the bone marrow or the blood of a third-party donor (allogeneic transplant) or the member (autologous transplant) and all component parts of the procedure; hospitalization and management of reasonably anticipated complications; infusion of the harvested stem cells; and processing and storage of the stem cells after harvesting.

***Benefit Description*:** The following transplants are eligible for coverage if they meet current evidence-based criteria:

- Allogeneic and autologous bone marrow or stem cell
- Autologous islet cell transplant (AICT)

- Cornea
- Heart; heart-lung; lung, kidney; kidney-liver; kidney-pancreas; liver; lung (lobar, single and double lung); pancreas; small bowel; and small bowel-multivisceral

Benefits are available for the following services in connection with, or in preparation for, a covered transplant:

- Inpatient and outpatient facility and professional services
- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member
- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Medical expenses incurred by a donor when the recipient is covered under the Plan. Covered donor expenses include complications and follow-up care related to the donation for up to six (6) months post-transplant, as long as the recipient's coverage with the Plan remains in effect.
- Pre-transplant testing and services
- Procurement of an organ from a cadaver or live donor, including surgery to remove the organ; transportation, hospitalization, and surgery of a live donor

In-network benefits are available for covered transplant services from in-network providers, providers contracted with BCBS, and Blue Distinction Centers for Transplants.

***Benefit-Specific Exclusions*:**

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by the Plan
- Transplants that do not meet current evidence-based criteria

Transplant or Gene Therapy Travel and Lodging

***Precertification*:** Not required

***Benefit-Specific Definition*: "**Caregiver" means the individual primarily responsible for providing daily care, basic assistance and support to a member who is eligible for transport, lodging, and reimbursement. Caregivers may perform a wide variety of tasks to assist the member in his or her daily life, such as preparing meals, assisting with doctors' appointments, giving medications or assisting with personal care and emotional needs.

***Benefit Description*:** Transplant travel and lodging expenses are eligible for reimbursement during evaluation, transplant, post-transplant care, and complications directly related to the transplant. Reimbursement is available for transplant or gene therapy travel and lodging expenses when **all** the following criteria are met:

- The Claims Administrator has precertified the service or if the Claims Administrator did not precertify the service, upon review the Claims Administrator determines that the service meets the requirements of the Plan
- The distance from the member's or caregiver's residence is more than sixty (60) miles from the facility
- The expenses are incurred by the member or the member's caregiver **and**
- The expenses are for any of the following:
  - Meal expenses
  - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; or bus, train or air fare

- Room charges from hotels, motels and hostels or apartment rental

***Benefit-Specific Maximum*:** Benefits are limited to a maximum of $10,000 per member, per transplant or gene therapy treatment. Covered expenses incurred by a Caregiver accumulate toward the member's $10,000 maximum.

***Benefit-Specific Exclusions*:**

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses incurred by a donor or the donor's Caregiver
- All travel and lodging expenses in excess of the benefit-specific maximums stated above
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with services that do not qualify for coverage under the Plan, noncovered transplant services, or any follow-up care, including treatment of complicantions
- Expenses for travel or lodging related to evaluation, consultation or medical testing to determine if a member is a candidate for a transplant
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members or Caregivers when the member or Caregiver does not travel more than sixty (60) miles for an authorized transplant or gene therapy-related services
- Vehicle maintenance or services (such as tires, brakes, or oil change)

***Claims for Reimbursement*:** To request reimbursement of eligible transplant and gene therapy travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to the Claims Administrator (see "Claim Forms & Where to File Claims " under "Internal Claim Procedures" in the **Plan Administration** section).

Urgent Care

***Precertification*:** Not required

***Benefit-Specific Definition*:** "Urgent care" means treatment for conditions that require prompt medical attention, but which are not emergencies.

***Benefit Description*:** Benefits are available for urgent care services. Providers contracted with the Plan Network as Urgent Care Centers are listed on the BCBSAZ website at www.azblue.com under "Urgent Care Centers."

Please be aware that the Plan Network includes some providers, such as hospitals, that offer urgent care services, but which are not specifically contracted with the Plan Network as urgent care providers. No matter what the circumstances, if you obtain urgent care services at a hospital or a hospital's on-site urgent care department, you'll be responsible for the applicable emergency room cost-share.

General Exclusions

NOTWITHSTANDING ANY OTHER PROVISION IN THE PLAN, NO BENEFITS WILL BE PAID FOR EXPENSES ASSOCIATED WITH THE FOLLOWING SERVICES. THESE EXCLUSIONS DO NOT APPLY FOR SERVICES THAT MUST BE COVERED ACCORDING TO APPLICABLE LAW:

Activity Therapy – Activity therapy and milieu therapy, including community immersion, integration, home independence and work re-entry therapy; any care intended to assist an individual in the activities of daily living; and any care for comfort and convenience, except for limited hospice benefits

Alternative Medicine – Non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; and aromatherapy

Bariatric Surgeries, if you are enrolled in Value or Core, Bariatric Surgeries are excluded if performed by Out-of-Network Providers

Benefit-specific exclusions, maximums, and limitations, listed in the **Prescription Drug Benefits** section or **Description of Medical Benefits** section

Biofeedback

Blood Administration for the purpose of general improvement in physical condition

Body Art, Piercing and Tattooing – Services related to body piercing, cosmetic implants, body art, tattooing and any related complications.

Care for health conditions that are required by state or local law to be treated in a public facility

Care required by state or federal law to be supplied by a public school system or school district

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by the following facilities are not covered: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes

Charges associated with the preparation, copying or production of health records

Cognitive and Vocational Therapy – Services related to improving cognitive functioning (i.e., higher brain functions), reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities and services related to employability

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under the Plan. Medical complications arising from an abortion are covered under the Plan.

Computer Speech Training, Therapy Programs and Devices

Consumable Medical Supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in the Plan

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations, and other services for Cosmetic purposes. This exclusion does not apply to breast reconstruction following a medically necessary mastectomy, medically necessary breast implant removal,

medically necessary surgery to improve or restore the impaired function of a body part or organ, or surgery to correct a congenital defect.

Cosmetics and health and beauty aids

Counseling – Counseling and behavioral modification services, except as stated in the Plan

Court-Ordered Services – Court-ordered testing, treatment and therapy, unless such services are otherwise covered under the Plan as determined by the Claims Administrator

Custodial Care

Dental – Except as stated in the Plan, dental and orthodontic services; placement or replacement of crowns, bridges or implants; any fixed dental reconstruction of the teeth; orthodontics; extractions of teeth; dentures; vestibuloplasty and surgical orthodontics; and any procedures associated with the services listed in this exclusion, including but not limited to procedures associated with dental implants and fitting of dentures

Dietary and Nutritional Supplements – All dietary, caloric and nutritional supplements, such as specialized formulas for infants, children or adults or other special foods or diets, even if prescribed, except as stated in the Plan

Domiciliary Care

Expenses for services that exceed benefit limitations or maximums

Experimental or Investigational Services or items, except as stated in the Plan

Fees – Fees that are (1) associated with the collection or donation of blood or blood products, (2) other than for medically necessary, in-person, direct member services, except as stated in the Plan,(3) for concierge medicine services, or (4) for direct primary care.

Fertility and Infertility Services – Services to improve or achieve fertility (ability to conceive) or to diagnose and and treat infertility (inability to conceive), except as stated in this Plan.

Flat Feet – Services for treatment of flat feet, weak feet and fallen arches. This exclusion does not apply to arch supports when medically necessary for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Foot Care – Services for foot care, including trimming of nails or treatment of corns or calluses, except when medically appropriate for diabetes, neurological involvement or peripheral vascular disease of the foot or lower leg

Free Services – Services you receive at no charge or for which you have no legal obligation to pay

Genetic and Chromosomal Testing, Screening and Therapy – Genetic and chromosomal testing, screening and therapy for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test, screening or therapy is performed, except as stated in the Plan

Government Services – Services provided at no charge to the member through a governmental program or facility

Growth Hormone – Growth hormone, except as specified in current evidence-based criteria. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

Habilitation Services – Except for certain limited services to treat autism spectrum disorder.

Hearing Aids and Associated Services, except as stated in the Plan

Hypnotherapy

Inpatient or Outpatient Long Term Care

Laboratory Services Provided Without an Order From an Eligible Provider

Lifestyle and work-related education and training, and management services

Lodging and Meals – Lodging and meals, except as stated in the Plan

Maintenance Services – Services provided after a member has met functional goals; services provided when no objectively measurable improvement is reasonably anticipated; services to prevent regression to a lower level of function; services to prevent future injury; and services to improve or maintain posture, except as stated in the Plan

Manipulation of the Spine Under Anesthesia

Marijuana – Medical marijuana, marijuana and any costs or fees associated with obtaining medical marijuana, such as obtaining an initial or renewal registry identification card, even when prescribed and obtained in compliance with state law(s)

Massage Therapy – Massage therapy, except in limited circumstances as described in current evidence-based criteria

Medical equipment, supplies, and medications sold on or through unregulated distribution channels as determined by the Claims Administrator, including online sources such as eBay, Craig's List or Amazon.com; or at garage sales, swap meets, and flea markets

Medications – Medications which are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in the Plan
- Not used in accordance with current evidence-based criteria
- Used to treat a condition not covered by the Plan **or**
- Off-label, unlabeled and orphan medications, except as stated in the Plan

Medications Dispensed in Certain Settings – Prescription medications given to the member, for the member's future use, by any person or entity that is not a licensed pharmacy, home health agency, or hospital emergency room

Member Costs or Fees associated with health clubs and weight loss programs

Neurofeedback

Non-Medically Necessary Services – Services that are not medically necessary as determined by the Claims Administrator, except as stated in the Plan (for example, Preventive Services are covered even though not medically necessary). The Claims Administrator may not be able to determine medical necessity until after services are provided.

Non-Medical Ancillary Services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy

Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription, except as stated in the Plan

Payments for exclusions imposed by any certification requirement

Payments for services that are unlawful in the location where the person resides at the time the expenses are incurred

Personal Comfort Services – Services intended primarily for assistance in daily living, socialization, personal comfort and convenience; homemaker services and services primarily for rest, domiciliary or convalescent care; costs for television, telephone, newborn infant photographs, meals other than meals provided to a member by an inpatient facility while the member is a patient in the inpatient facility, and birth announcements; and other services and items for other non-medical reasons

Phase 3 Cardiac Rehabilitation

Prescription Medications Obtained from a Retail or Mail Order Pharmacy or Specialty Pharmacy.

Private Duty Nursing

Refills or Replacements – Refills or replacements for medications covered under the Plan that are lost, stolen, spilled, spoiled or damaged

Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic, or custodial evaluations

Reproductive Services – Procedures, treatment, office visits, consultations and other services related to the genetic selection and/or preparation of embryos and implantation services including, but not limited to, pre-implantation genetic diagnosis and in-vitro fertilization and related services, except as stated in the Plan

Respite Care, except as covered in the Hospice Services benefit (see "Hospice Services" in the **Description of Medical Benefits** section)

Reversal of Surgical Procedures, except as stated in current evidence-based criteria and other criteria, as determined by the Claims Administrator

Screening Tests – Any testing performed on an individual who does not have a specific diagnosis or acute signs or symptoms of a condition or disease for which the test is being performed, regardless of whether the individual has a family history or other risk factors for the disease or condition, except as stated in the Plan

Sensory Integration and Music Therapy

Service Animals and related costs, including but not limited to food, training and veterinary costs

Services for Children of a Dependent, unless the child is also eligible and enrolled in the Plan as an employee's dependent

Services for Idiopathic Environmental Intolerance – Services associated with environmental intolerance from unknown causes (idiopathic), multiple chemical sensitivity, the diagnosis or treatment of environmental illness (clinical ecology), such as chemical sensitivity or toxicity from exposure to atmospheric or environmental contaminants, pesticides or herbicides

Services for Weight Loss and Gain, except as stated in the Plan

Services from Ineligible Providers

Services for Conditions Medicare Identifies as Hospital-Acquired Conditions (HACs), and/or National Quality Forum (NQF) "Never Events"

Services Paid for By Other Organizations or those Required by Law to be Paid for By Other Organizations – Services paid for by other organizations and/or services required by law to be paid for by other organizations. Other organizations include, but are not limited to, the government, a school, and/or biotechnical, pharmaceutical, medical or dental device industry organizations.

Services Prior to Member's Coverage Effective Date

Services Provided After the Member's Coverage End Date, except as stated in the Plan

Services Provided by Out-of-Network Providers (if you're enrolled in Premium), except for emergencies, ambulance services, eosinophilic gastrointestinal disorder, and Medical Foods formulas; if you're enrolled in Value or Core, see the applicable Cost-Share Summary for certain benefits that are not covered out-of-network

Services Related to or Associated with Noncovered Services –

Services Without A Prescription – Services and supplies that are required by the Plan to have a prescription and are not prescribed by a physician or other provider licensed to prescribe

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause, and medications for the treatment of sexual dysfunction

Spinal Decompression or Vertebral Axial Decompression Therapy (VAX-D)

Strength Training – Services primarily designed to improve or increase fitness, strength or athletic performance, including strength training, cardiovascular endurance training, fitness programs and strengthening programs, except as stated in the Plan

Telephonic and Electronic Consultations – Telephonic and electronic consultations, except as stated in the Plan

Therapy Services, except as stated in the Plan

Therapy to Improve General Physical Condition including, but not limited to, inpatient and outpatient routine long-term acute care

Training and Education – Training and education, except as stated in the Plan

Transportation – Transport services and travel expenses, except as stated in the Plan

Vision – Routine vision exams, except for preventive vision screenings for members under age 5; vision therapy; eye exercises; all types of refractive keratoplasties including but not limited to radial keratotomy and/or lasik surgery; any other procedures, treatments and devices for refractive correction; eyeglass frames and lenses, contact lenses and other eyewear; and vision examinations for fitting of eyeglasses and contact lenses, except as stated in the Plan

Vitamins – All vitamins, minerals and trace elements that are lawfully obtainable without a prescription, except as stated in the Plan

Wigs and hairpieces, except as stated in the Plan

Workers' Compensation – Services to treat illnesses and injuries which are covered by Workers' Compensation. This exclusion does not apply if the member has made a statutory opt-out election and/or is exempt from Workers' Compensation coverage.

Plan Administration

Plan Administrator

The Plan Administrator has the responsibility and discretionary authority to administer the Plan in accordance with its terms. A decision or action of the Plan Administrator with respect to any question arising out of or in connection with the administration, interpretation, or application of the Plan and the rules, policies, or procedures adopted by the Plan Administrator will be final, conclusive and binding on all persons. Decisions by the Plan Administrator may not be overturned unless found by a court to be arbitrary and capricious and having no foundation.

The Plan Administrator's powers and duties include the full power and discretionary authority to: (1) establish a funding method consistent with the objectives of the Plan and ERISA, (2) make and enforce rules, policies, or procedures as it deems necessary or desirable for the efficient administration of the Plan, (3) construe and interpret the Plan, including all possible ambiguities, inconsistencies, or omissions, (4) decide all questions concerning the Plan (including questions of fact) and the eligibility of any person to participate in the Plan, (5) appoint or employ agents, counsel, accountants, consultants and other persons as it deems necessary or desirable to assist in administering the Plan, (6) allocate or delegate its responsibilities under the Plan, including designating fiduciaries other than or in addition to those named in the Plan and allocating or reallocating fiduciary responsibilities under the Plan, and (7) take any other actions as it determines is necessary or desirable in carrying out its duties. To the extent the Plan Administrator delegates its responsibilities under the Plan, references to the Plan Administrator mean the person, entity, or committee to whom those responsibilities are delegated.

Claims Administrator

The Claims Administrator for each benefit (i.e., prescription drug benefit and medical benefit) is responsible for: (1) determining eligibility for benefits and the amount (if any) payable for benefits, (2) determining whether a service or prescription drug subject to precertification or prior approval should be precertified or approved, and (3) processing payment of benefits. The Claims Administrator does not insure, guarantee, or assume any financial risk or obligation to provide any benefits under the Plan since the Plan is self-funded (see "Self-Funded Status" under "Additional Information" in the **Other Important Information** section).

Claims for benefits are payable only to the extent the Claims Administrator determines they are payable. In evaluating and making claims decisions, the Claims Administrator has the full power and discretionary authority to interpret and apply the terms of the Plan. Decisions by the Claims Administrator may not be overturned unless found by a court to be arbitrary and capricious and having no foundation (or, in the case of claim denial which is eligible for and sent to external review, overturned by the independent review organization).

Internal Claim Procedures

The Plan's internal claim procedures described below will be administered and interpreted in compliance with the ERISA claim procedures requirements. References in this "Internal Claim Procedures" and in "External Review of Claims" below to "you" include your authorized representative (if any). Your authorized representative is the person you authorize (in the form and manner required by the Claims Administrator) to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a provider with knowledge of your condition may act as your authorized representative.

Filing Claims

Claims for benefits must be filed with the applicable Claims Administrator. It's your responsibility to ensure claims are timely filed (see "Time Limit for Claim Filing" below), but in most cases, in-network providers and in-network

pharmacies will file your claim for you. Make sure you or your providers file all your claims so the Claims Administrator can track your covered expenses and properly apply them toward applicable deductibles, coinsurance, out-of-pocket maximums and benefit maximums/limits.

If you choose to pay a provider on a direct pay basis and submit a receipt to the Claims Administrator, the Claims Administrator will credit your deductibles and out-of-pocket maximums as required by applicable law. You must submit a receipt that includes the amount paid, the procedure and diagnosis codes for the services provided and a notation indicating direct payment.

Time Limit for Claim Filing

A complete claim (see "Complete Claims" below) must be filed within one year from the date of service or the date the prescription is filled. Remember, however, that certain services, medications, and prescription drugs require precertification or prior authorization to be either covered or not subject to a precertification charge (see "Precertification Requirements" in the **Medical Benefits Overview** section and "Prior Authorization" in the **Prescription Drug Benefits** section). Any claim not filed with all required content within the one-year period is an untimely claim. The Claims Administrator will deny an untimely claim except in very limited circumstances where the Claims Administrator determines the claim was not timely filed for reasons outside of the member's control or for good reason. Examples include situations where the Claims Administrator gave the member incorrect information about a deadline or the member had an extended illness that prevented him or her from filing the claim.

Claim Forms & Where to File Your Claim

If you want or need to file a claim, you'll need a claim form. Claim forms for medical benefits are available online at www.azblue.com (go to the "Forms" section of the "Member" area) or by calling the BCBSAZ customer service number on your ID card. Claim forms for prescription drug benefits are available online at www.caremark.com or by calling the CVS Caremark customer service number on your ID card.

Send claims for prescription drugs to:

CVS Caremark
PO Box 52196
Phoenix, AZ 85072-2196

Send claims for medical benefits (other than the specific ones listed below) to:

Blue Cross Blue Shield of Arizona
PO Box 2924
Phoenix AZ 85062-2924

Send claims for the Transplant and Gene Therapy Travel and Lodging benefit to:

Attention: Transplant Travel Claim Processor
Mail Stop: A223
Blue Cross Blue Shield of Arizona
PO Box 13466
Phoenix, AZ 85002-3466

Send claims for the Chiropractic Services benefit to:

Claims Administrator
American Specialty Health Networks, Inc.
PO Box 509001
San Diego, CA 92150-9001

Complete Claims

For medical benefits, a complete claim includes, at a minimum, the following information and such other information as the Claims Administrator may require:

- Billed charges
- Date of service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number

For prescription drug benefits, a complete claim includes, at a minimum, the following information and such other information as the Claims Administrator may require:

- Your member ID
- Your account number (i.e., the seven-digit policy number included on your ID card)
- A copy of the receipt (not cash register tape) for the prescription drug which includes, at a minimum:
  - the patient's name
  - the prescription number
  - the total charge
  - the date filled
  - the days supply
  - the NABP/NPI (National Association of Boards of Pharmacy/National Provider Identifier) of the pharmacy that filled the prescription
  - the pharmacy name
  - the pharmacy address

The Claims Administrator may reject claims that are filed without complete information needed for processing. If the Claims Administrator rejects a submitted claim due to lack of information, the Claims Administrator will notify you or the provider or pharmacy who submitted the claim. Lack of complete information may also delay processing.

Other Information Needed to Process a Claim

Even when the claim has all of the information listed above, the Claims Administrator may need to request medical or dental records or coordination of benefits information to make a coverage decision. If the Claims Administrator has requested medical records or other information from a third party, the Claims Administrator will suspend claim processing while the request is pending. The Claims Administrator may deny a claim for lack of timely receipt of requested records.

If records are needed, in-network providers generally cannot charge you for providing the Claims Administrator with records. Out-of-network providers may have no contractual obligation to provide records to the Claims Administrator free of charge. If you receive services from an out-of-network provider who charges for record preparation or the cost of copies, you'll need to arrange with your provider to obtain any records required by the Claims Administrator and pay any applicable fees.

Time Period for Claim Decisions

Post-Service Claims

A post-service claim is a claim relating to a service you've already received or a prescription drug you've already filled. Within 30 days after receiving your claim, the Claims Administrator will make a decision on your claim or notify you if an extension of up to 15 days is needed. If an extension is needed, the notice will tell you the expected date for a decision and what additional information (if any) is needed to process your claim. If additional information is needed, you'll have at least 45 days to submit it. In that case, the time period for the Claims Administrator to decide your claim will be tolled (i.e., suspended) until the 45-day period ends (or, if earlier, until the additional information is provided).

Pre-Service Claims

A pre-service claim is a claim relating to a service you haven't already received because it's subject to precertification or a prescription drug you haven't already received because it's subject to prior authorization. Within 15 days after receiving a precertification or prior authorization request, the Claims Administrator will make a decision on your claim or notify you if an extension of up to 15 days is needed. If an extension is needed, the notice will tell you the expected date for a decision and what additional information (if any) is needed to process the precertification or prior authorization request. If additional information is needed, you'll have at least 45 day to submit it. In that case, the time period for the Claims Administrator to decide your claim will be tolled (i.e., suspended) until the 45-day period ends (or, if earlier, until the additional information is provided).

Urgent Care Claims

An urgent care claim is a claim for services or prescription drugs for which the application of the non-urgent time periods could seriously jeopardize your life, health or ability to regain maximum function **or** in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When you request coverage for an urgent care claim, a decision will be made as soon as possible in accordance with medical exigencies, but no later than 72 hours after receipt of the request. However, if additional information is needed, the Claims Administrator will notify you or your provider within 24 hours after receipt of your request. In that case, you'll have 48 hours to provide the information and the time period for the Claims Administrator to decide your claim will be tolled (i.e., suspended) until the 48-hour period ends (or, if earlier, until the additional information is provided).

Concurrent Care Decisions

A concurrent care decision is a decision relating to your or your provider's request to extend a plan of care which has already been precertified. Examples include extending the amount of time or number of visits previously approved for the plan of care.

If the request involves urgent care and is made at least 24 hours before the expiration of the existing plan of care, the Claims Administrator will make a decision as soon as possible in accordance with medical exigencies, but no later than 24 hours after receipt of the request. If your request is not made at least 24 hours prior to the expiration of the existing plan of care, the Claims Administrator will make a decision as soon as possible in accordance with medical exigencies, but no later than 72 hours after receipt of the request. If your request is denied, you may appeal the denial in the same way you appeal any other coverage denial.

Explanation of Benefits & Monthly Statement for Medical Benefits

After your medical claim is processed, the Claims Administrator will send you an explanation of benefits ("EOB"). Most EOBs are consolidated and sent to you in a monthly member health statement rather than as single EOBs. Your EOBs also will be available through the member portal on www.azblue.com. An EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-share amounts. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually

collects from you or bills to you. If you paid more cost-share than required for a covered service, the Claims Administrator may refund that amount to an in-network provider, and the provider will be responsible for refunding you. Your EOB will show any refunds for cost-share overpayments. The Claims Administrator will also send your in-network provider the information that appears on your EOB. This information is not sent to out-of-network providers. Out-of-network providers do not receive any written information on how much was paid on a claim or the reasons for how the claim was processed. Save the EOB for your personal records as there may be a fee for duplication of claims records.

Notice of Adverse Benefit Decision

If your request for precertification of a medical benefit, prior authorization of a prescription drug benefit, or claim for a medical or prescription drug benefit is denied, in whole or in part, you'll receive a notice of adverse benefit decision. For medical benefits, your EOB or monthly statement will typically serve as the notice.

Examples of adverse benefit decisions include:

- a denial (in whole or in part) of your request for precertification of a service you haven't received or for prior authorization of a prescription drug you haven't received
- a denial (in whole or in part) of a claim for services or prescription drugs you've already received
- a denial, reduction, or termination of your Plan benefits (in whole or in part)
- a finding that you're responsible for payment of a cost-share (e.g., copay, deductible, coinsurance, balance bill) for a Plan benefit
- a finding that a service or prescription drug is not medically necessary or not covered because it is experimental or investigational
- a decision that you're not eligible for coverage under the Plan
- a retroactive rescission (i.e., cancellation) of your coverage without regard to whether it has an adverse effect on a particular benefit at the time the rescission occurs (note: this doesn't include a retroactive cancellation of your coverage due to your not paying premiums)

The notice of adverse benefit decision will:

- state the specific reason(s) for the adverse benefit decision (e.g., not covered because the provider is ineligible or because services are not covered under the Plan)
- reference the specific plan provision on which the decision is based
- describe additional material or information, if any, needed to process the claim and the reasons such material or information is necessary
- describe the applicable appeal procedures
- disclose any internal rule, guideline or protocol relied on in making the adverse benefit decision (or state that such information is available free of charge upon request)
- if the denial is based on medical necessity, experimental treatment, or a similar limit, explain the scientific or clinical judgment for the adverse benefit decision (or state the information will be provided free of charge upon request)

Appealing an Adverse Benefit Decision

If there's an adverse benefit decision (see examples above in "Notice of Adverse Benefit Decision"), you'll have the right to request an appeal (i.e., review of) the decision, free of charge. You must file a request for appeal within the applicable time period described below. **If you don't timely appeal the decision, the decision will be final, binding, and nonappealable** (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below).

The notice of adverse benefit decision will include information about your right to appeal and the address where you should send your request for appeal. It may also include (or refer you to) forms which you may use for your appeal. To request an appeal of an urgent care claim by telephone, call the number on your ID card.

If you timely appeal an adverse benefit decision, the Claims Administrator will conduct a full and fair review of the adverse benefit decision. The reviewer will be someone who was not involved in the adverse benefit decision and who is not compensated, rewarded, or promoted for upholding the adverse benefit decision. For adverse benefit decisions involving a medical judgment, the review will be performed by a health care professional who has the appropriate training and expertise in the field of medicine involved in the claim.

In connection with your appeal, you may request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to your claim. You can also request a copy of the specific rule, guideline, or protocol relied upon in making the adverse benefit decision, which will be provided to you free of charge. If the adverse benefit decision was based on medical necessity, experimental treatment, or a similar limit, you can request an explanation of the scientific or clinical judgment for the decision, which will be provided to you free of charge.

Medical Benefit Appeals

There are three types of medical benefit appeals discussed below. Each type has a two-level appeal process. The first level is required, meaning **you have to go through a first level appeal in order to exhaust the Plan's internal claim procedures for medical benefits**. The second level is voluntary, meaning you don't have to go through a second level appeal in order to exhaust the Plan's internal claim procedures for medical benefits.

***Important Information About Expedited External Review of an Urgent Care Claim*:** If the time period for completing an internal expedited appeal of your urgent care claim would seriously jeopardize your life or health or your ability to regain maximum function, you may be eligible to request and receive an expedited external review of your claim (see "External Review of Claims" below). In that case, you can skip the internal appeal process, go straight to an expediated external review, and will be deemed to have exhausted the Plan's internal claim procedures for medical benefits.

Standard Appeal

An appeal of an adverse benefit decision is a standard appeal if it's not a cost-share appeal (i.e., an appeal relating to your cost-share amount or the Plan's allowed amount) or an expediated appeal of an urgent care claim.

If your appeal is a standard appeal, you must file a request for a first level appeal within **2 years** after you receive the adverse benefit decision. Your request should include, at a minimum, the following information and such other information as the Claims Administrator may require:

- the decision or action you disagree with and wish to appeal
- why you think the original decision is wrong
- what you are asking the Claims Administrator to do differently
- any medical records that support your request
- any other information you want the Claims Administrator to consider

The Claims Administrator will acknowledge receipt of your request for a first level appeal within 5 business days and will notify you of its decision within 30 days after receiving your request for a first level appeal.

If you disagree with the Claims Administrator's first level appeal decision, you can:

- request a voluntary second level appeal within **60 days** after you receive the first level appeal decision,
- request an external review within **4 months** after you receive the first level appeal decision ***if*** your claim is eligible for external review (see "External Review of Claims" below), or

- file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

If you request a voluntary second level appeal and your claim is eligible for external review, the Claims Administrator may decide to skip the second level appeal and instead send your claim to external review, in which case the external review provisions will apply. If your claim isn't eligible for external review or the Claims Administrator decides to not skip the second level appeal, the Claims Administrator will notify you of its second level appeal decision within 30 days (if your claim is a pre-service claim) or 60 days (if your claim is a post-service claim) after receiving your request for second level appeal.

If you disagree with the Claim Administrator's second level appeal decision, you can:

- request an external review within **4 months** after you receive the second level appeal decision ***if*** your claim is eligible for external review (see "External Review of Claims" below), or
- file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

Cost-Share Appeal

An appeal of an adverse benefit decision is a cost-share appeal (also called a member grievance) if the adverse benefit decision is about your cost-share amount or the Plan's allowed amount.

If your appeal is a cost-share appeal, you must file a request for a first level appeal within **1 year** after you receive the adverse benefit decision (or by such later date as may be expressly permitted by the Claims Administrator, in its sole discretion, for good cause, such as a death in your immediate family).

The Claims Administrator will notify you of its decision within 30 days (if your claim is a pre-service claim) or 60 days (if your claim is a post-service claim) after receiving your request for first level appeal.

If you disagree with the Claims Administrator's first level appeal decision, you can:

- request a voluntary second level appeal within **60 days** after you receive the first level appeal decision, or
- file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

If you request a voluntary second level appeal, the Claims Administrator will notify you of its decision within 30 days (if your claim is a pre-service claim) or 60 days (if your claim is a post-service claim) after receiving your request for a second level appeal.

If you disagree with the Claim Administrator's second level appeal decision, you can file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below).

Note: In most cases, claims subject to a cost-share appeal don't involve questions of medical judgment and therefore aren't eligible for external review. However, if your claim did involve a question of medical judgment, you'd also have the option of requesting an external review within 4 months after you receive the Claims Administrator's first or second level appeal decision.

Expediated Appeal (for Urgent Care Claims)

There's an expedited appeal process for urgent care claims. Your request for an expediated appeal should be filed **promptly** after you receive the adverse benefit decision. Your request should include, at a minimum, the following information and such other information as the Claims Administrator may require:

- the decision or action you disagree with and wish to appeal
- why you think the original decision is wrong

- what you are asking the Claims Administrator to do differently
- any medical records that support your request
- any other information you want the Claims Administrator to consider

The Claims Administrator will notify you of its decision within 72 hours after receiving your request for a first level appeal.

If you disagree with the Claims Administrator's first level appeal decision, you can:

- request a voluntary second level appeal within **60 days** after you receive the first level appeal decision,
- request an external review within **4 months** after you receive the first level appeal decision ***if*** your claim is eligible for external review (see "External Review of Claims" below), or
- file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

If you request a voluntary second level appeal, the Claims Administrator will notify you of its decision within 3 business days after receiving your request for a second level appeal.

If you disagree with the Claims Administrator's second level appeal decision, you can:

- request an external review within **4 months** after you receive the second level appeal decision ***if*** your claim is eligible for external review (see "External Review of Claims" below), or
- file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

Prescription Drug Benefit Appeals

You must file a request for appeal of an adverse benefit decision regarding prescription drug benefits within **180 days** after receiving the adverse benefit decision. Your request for appeal should include, at a minimum, the following information and such other information as the Claims Administrator may require:

- a clear statement that the communication is intended to appeal an adverse benefit decision
- the name and date of birth of the person for whom the appeal is being filed
- the CVS Caremark identification number
- a statement of the issue(s) being appealed
- the drug name(s) being requested
- comments, documents, records, relevant clinical information or other information relating to your claim

As discussed below, some prescription drug benefit claims have a one-level appeal process. **If the one-level appeal process applies to your claim, you have to go through the one-level appeal process in order to exhaust the Plan's internal claim procedures for prescription drug benefits.** Other prescription drug claims have a two-level appeal process. **If the two-level appeal process applies to your claim, you have to go through <u>both</u> levels of the two-level appeal process in order to exhaust the Plan's internal claim procedures for prescription drug benefits**. In other words, the second level of the two-level appeal process is required, not voluntary.

***Important Information About Expedited External Review of an Urgent Care Claim*:** If the time period for completing an internal expedited appeal of your urgent care claim would seriously jeopardize your life or health or your ability to regain maximum function, you may be eligible to request and receive an expedited external review of your claim (see "External Review of Claims" below). In that case, you can skip the internal appeal process, go straight to an expediated external review, and will be deemed to have exhausted the Plan's internal claim procedures for prescription drug benefits.

One-Level Appeal Process

The one-level appeal process applies to all post-service claims. It also applies to pre-service claims and urgent care claims ***if*** the adverse benefit decision being appealed:

- is based solely on the terms of the Plan and related documents (such as the Claims Administrator's formulary or preferred drug list) **and**
- doesn't involve a question about whether the prescription drug was medically necessary or experimental or investigational

The Claims Administrator will notify you of its appeal decision within the following time period after receiving your request for appeal:

- 72 hours if your claim is an urgent care claim
- 30 days if your claim is a pre-service claim
- 60 days if your claim is a post-service claim

If you disagree with the Claims Administrator's appeal decision, you can:

- request an external review within **4 months** after you receive the appeal decision if your claim is eligible for external review (see "External Review of Claims" below), or
- file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

Two-Level Appeal Process

The two-level appeal process applies to all pre-service claims and urgent care claims that aren't subject to the one-level appeal process described above (for example, a pre-service claim which involves a question of medical necessity).

For a pre-service claim subject to the two-level appeal process:

- the Claims Administrator will notify you of its first level appeal decision within 15 days after receiving your request for appeal
- if you disagree with the first level appeal decision, you must request a second level appeal within **180 days** after receiving the first level appeal decision
- if you timely request a second level appeal, the Claims Administrator will notify you of its second level appeal decision within 15 days after receiving your request for a second level appeal
- if you disagree with the second level appeal decision, you can:
    - request an external review within **4 months** after you receive the second level appeal decision ***if*** your claim is eligible for external review (see "External Review of Claims" below), or
    - file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

For an urgent care claim subject to the two-level appeal process:

- the time period for the Claims Administrator to notify you of its first (and, if requested, second) level appeal decision is a combined total of 72 hours
- if you disagree with the first level appeal decision, you must request a second level appeal within **180 days** after receiving the first level appeal decision
- if you disagree with the second level appeal decision, you can:
    - request an external review within **4 months** after you receive the second level appeal decision ***if*** your claim is eligible for external review (see "External Review of Claims" below), or

- file a legal or equitable action against the Plan within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" below)

Required Exhaustion of Internal Claim Procedures & Statute of Limitations, Venue, and Arbitration

Before filing any legal or equitable action for benefits or coverage under the Plan, you must exhaust the Plan's internal claim procedures, as described above. If you don't exhaust the Plan's internal claim procedures, the Claims Administrator's decision will be final, binding, and nonappealable, meaning you won't be able to file a legal or equitable action relating to your denied claim.

If you exhaust the internal claim procedures and decide to file a legal or equitable action, you must file the action within **3 years** from the deadline for filing claims (see "Time Limit for Claim Filing" above). This is called a statute of limitations, and you can't file a legal or equitable action after the statute of limitations ends. If you have a medical benefit claim and decide to request a voluntary second level appeal, the Plan's 3-year statute of limitations will be tolled (i.e., will not run) while the second level appeal is pending.

If your claim is eligible for external review, the external review process gives you a more economical way of having your denied claim reviewed by an independent party (i.e., an independent review organization), but you don't have to get an external review before filing a legal or equitable action relating to your denied claim. If you go through an external review, the Plan's 3-year statute of limitations will be tolled (i.e., will not run) while the external review is pending.

Jurisdiction and venue for any legal action or other proceeding that arises out of or relates to the Plan shall be solely in a court of competent jurisdiction that is located in Maricopa County Arizona.

Any dispute arising directly or indirectly out of the Plan must be resolved by binding arbitration to the fullest extent permitted by applicable law. You agree that neither class or collective claims, nor class action or collective action procedures, will be asserted in, or will apply to, any dispute that arises out of the Plan. You irrevocably and unconditionally waive, to the fullest extent permitted by applicable law, any right to a trial by jury in any dispute arising out of or relating to the Plan.

External Review of Claims

You may request an external review of any adverse benefit decision that is eligible for external review. An expedited external review is available if the normal time frames would seriously jeopardize your health or life or your ability to regain maximum function.

An adverse benefit decision will be eligible for external review if:

- your claim (or the denial of your claim) involves a rescission of coverage or a medical judgment (such as a requirement or exclusion regarding medical necessity, medical appropriateness, health care setting, level of care, benefit effectiveness, or experimental or investigational)
- you've exhausted all of the Plan's required internal appeals (or the time period for completing an expedited internal appeal of your urgent care claim would seriously jeopardize your life or health or your ability to regain maximum function) **and**
- you have provided all information/forms required to process the external review

Note: External review is not available for denials based on lack of member eligibility or for payment disputes that don't involve questions of medical judgment.

Your request for external review must be filed in the form and manner required by the Claims Administrator within **4 months** after your receipt of the final internal adverse benefit decision for which you're requesting external review.

If you timely request an external review:

- within 5 business days of receiving your request (or immediately upon receipt of your request in the case of an expedited external review of an urgent care claim), the Claims Administrator will perform a preliminary review of your request to determine if your claim qualifies for external review
- within 1 business day after completing the preliminary review, the Claims Administrator will notify you, in writing, of its decision
- if your request is not complete, the notification will describe the information or materials needed to make the request complete and you'll have until the end of the 4-month filing period (or, if later, 48 hours following your receipt of the notification) to provide the missing or incomplete information or materials
- if your request is complete but the Claims Administrator determines your claim does not qualify for external review, the notification will include the reasons your claim does not qualify and contact information for the Employee Benefits Security Administration

If your claim qualifies for external review:

- the Claims Administrator will assign your claim to an independent review organization
- the independent review organization will notify you, in writing, of its acceptance of the review and provide you with at least 10 days to provide any additional information, which the independent review organization will take into account in its review of your claim
- if you provide the independent review organization with new information, the independent review organization will send that information to the Claims Administrator within 1 business day and the Claims Administrator may decide to change its internal decision, in which case it will notify you and the independent review organization of the change
- if new information is not provided (or the Claims Administrator doesn't change its internal decision), the independent review organization will use neutral, independent physicians with appropriate expertise in the area in question to review and determine your claim and will not be bound by any decisions or conclusions made by the Claims Administrator during the Plan's internal claim procedures process
- the independent review organization will notify you and the Plan of its decision within 45 days of its receipt of your request for external review (or within 72 hours in the case of an expedited external review of an urgent care claim)

The independent review organization's decision will be binding on the Plan. This means that if the independent review organization determines that the denial of your claim should be reversed, the Plan will immediately provide coverage or payment for your claim. If the independent review organization doesn't reverse the denial of your claim (or only reverses the denial in part), you'll have the right to bring a legal or equitable action against the Plan should you decide to do so, in which case the action must be brought within the Plan's **3-year** statute of limitations (see "Required Exhaustion of Internal Claim Procedures & Statute of Limitations" above).

Payments to Others & Medicaid Reimbursements

The Claims Administrator may pay an amount owed to a person under the Plan to another person if the Claims Administrator believes the person to whom the amount is owed (1) is unable to care for his or her affairs because of sickness, injury, or other condition, (2) is a minor, or (3) has died. The other person to whom payment may be made includes the spouse, child, relative, or institution maintaining or having custody of the person to whom the amount is owed, or any other person the Claims Administrator believes is a proper recipient on behalf the person to whom the amount is owed. To the extent a payment is made to any such other person, the payment will be

deemed to have been made (and treated as having been made for purposes of the Plan's obligations) to the person to whom the amount is owed. This right does not obligate the Claims Administrator to investigate or take any actions to determine whether (or not) a person is capable of caring for his or her affairs, is a minor, or is deceased.

State Medicaid agencies, including the Arizona Health Care Cost Containment System, (collectively, "Medicaid Agency") are considered payers of last resort for medical expenses of individuals who are Medicaid beneficiaries. As a result, if a member receives benefits under the Plan and is also a Medicaid beneficiary, the Plan will (to the extent required by applicable law) reimburse the Medicaid Agency for medical expenses covered by the Medicaid Agency. These reimbursements typically won't exceed the lesser of the member's benefit under the Plan or medical expenses covered by the Medicaid Agency.

Omissions, Misstatements, Misrepresentations or Fraud

If there's an intentional or unintentional omission (for example, a failure to notify the Claims Administrator of a change which affects eligibility, see "Keeping the Plan Informed of Changes" in the **Understanding Your Plan** section), misstatement, or misrepresentation or there's a fraud, the true facts will be used to determine eligibility, coverage and the benefits due under the Plan. If, based on the true facts, a person is not eligible for coverage or the claim is for benefits not payable under the Plan (or not payable to the extent requested in the claim), the Claims Administrator may terminate coverage, deny the claim (in whole or in part), and/or recover any amounts that would not have been paid had the omission, misstatement, misrepresentation or fraud not occurred, plus all costs of collection including attorneys' fees and court costs (see also "Recovery of Incorrect & Over Payments" below).

In the case of fraud or an intentional misrepresentation of fact which affects an individual's eligibility for coverage, the individual's coverage may be rescinded (i.e., retroactively terminated such that the coverage is treated as never having been in effect) to the extent permitted by applicable law. A rescission of coverage is an adverse benefit decision (i.e., claim denial) for purposes of the Plan's claim procedures (see "Internal Claim Procedures" in the **Plan Administration** section), which can be appealed. If coverage is rescinded, premiums paid for the rescinded coverage (minus any claims paid) will be refunded, and the Claims Administrator may recover any claims paid which are in excess of the premiums paid (see also "Recovery of Incorrect & Over Payments" below). Any rescission of coverage will not affect the coverage of any person who, based on the true facts, remains eligible for coverage.

Coordination of Benefits (COB)

If you or your dependents (collectively, "you" for these coordination of benefits provisions) have medical coverage in addition to coverage under this Plan, the amount of benefits payable under this Plan will be coordinated with your other coverage. This is called coordination of benefits and it's intended to avoid duplicate benefits. For this purpose, your other medical coverage includes coverage under a group health plan (whether insured or self-funded), individual health insurance, and to the extent permitted by law, Medicare. This Plan doesn't apply coordination of benefits to the prescription drug benefits under the Plan, meaning your prescription drug benefits under the Plan won't be affected by any other prescription drug coverage you might have.

When coordination of benefits applies, the rules described below are used to determine which coverage (i.e., this Plan or your other medical coverage) pays first (i.e., which coverage is primary). This Plan's payment of the claim will still be subject to all applicable cost-sharing (e.g., deductibles, coinsurance, and copays), and the combined benefits (from this Plan and your other medical coverage) will not exceed the amount this Plan would have paid if you didn't have other coverage.

If your other medical coverage is primary, the combined benefits (from this Plan and the other coverage) will not exceed the greater of the primary payer's or this Plan's allowed amount.

If your other medical coverage doesn't have a coordination of benefits provision, that coverage is primary and pays first. If your other medical coverage has a coordination of benefits provision, the following rules will be used to determine which coverage is primary and will pay first:

- If the person is an inpatient on the day this Plan becomes effective and benefits are payable under the person's prior medical plan for the inpatient stay, the prior medical plan pays first.
- If the person who received care is covered as an active employee under one plan and as a dependent under another, the plan which covers the person as an active employee pays first.
- If the person who receives care is covered as an active employee under one plan and as an inactive employee under another, the plan which covers the person as an active employee pays first.
- If the person who receives care is a dependent child and the dependent child's parents are not legally separated or divorced:
    - the plan of the parent whose birthday occurred earlier in a calendar year pays first, or
    - if both parents have the same birthday, the plan that covered a parent longer pays first, or
    - if one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule will determine which plan pays first.
- If the person who receives care is a dependent child and the dependent child's parents are legally separated or divorced, the following applies:
    - If a court decree specifies a parent who is financially responsible for the child's medical expenses, the specified parent's plan pays first.
    - If there's no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's plan pays second. The non-custodial parent's plan pays last.
    - If the parents have joint custody, the plan of the parent whose birthday occurred earlier in a calendar year pays first.

When none of the above applies, the coverage you have had for the longest continuous period of time pays first.

If you have coverage under Medicare, Medicare guidelines will be used to determine the primary payer. If the provider accepts assignment from Medicare, the combined payments by Medicare and the Plan will not exceed the Medicare allowed amount. If the provider does not accept assignment from Medicare the combined payments by Medicare and the Plan will not exceed the provider's billed charges. If the provider opts-out of Medicare, the Plan is the primary payer. BCBSAZ will pay primary without regard to the member’s other coverage.

Non-Duplication of Benefits

If services are covered under this Plan and one or more other group health plans that are issued or administered by BCBSAZ, the rules described above in "Coordination of Benefits" will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that the Plan would have paid if you had no other coverage.

If services are covered under this Plan and one or more BCBSAZ individual contracts, benefits will be paid first under the individual contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed 100% of the amount the Plan would have paid if you had no other coverage. The Plan doesn't coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ. BCBSAZ will pay primary without regard to the member’s other coverage.

Subrogation

If you or your dependents (collectively, "you" for these subrogation provisions) receive benefits under the Plan due to an accident or condition caused by another person, the subrogation provisions described below will apply to the benefits you receive. These subrogation provisions apply only to medical benefits payable under the Plan (i.e., they don't apply to prescription drug benefits payable under the Plan).

Here is the way subrogation works. Sometimes you require hospital and/or medical services due to an injury in an accident or due to a condition caused by another person's negligence. In such cases, the person causing the accident ("third party") is responsible for payment of your hospital and medical expenses. This Plan, which pays for your covered hospital and medical services, has the right to recover these payments from the third party or from you if you have recovered from the third party. When the Plan exercises its rights to be reimbursed, the process is known as subrogation, recovery and/or reimbursement (collectively, "subrogation").

During the subrogation process, the Claims Administrator, on behalf of the Plan, will continue to pay your covered hospital and medical services on behalf of the Plan just as it always has. However, if a third party is legally obligated to pay for your expenses, the Plan will then exercise its rights to be reimbursed for 100% of what the Plan has paid (and will pay) for the services due to the injury/accident without any reduction for attorneys' fees and/or court costs and regardless of whether you were made whole. In addition, the Plan has first priority from any judgment, payment or settlement.

The Plan's rights apply to any settlement of a claim regardless of whether anyone has started litigation. The Plan's rights apply without regard to whether you've been "made whole" (i.e., without regard to whether you've been fully compensated for your injuries). The Plan may subrogate against all money that you or anyone recovers regardless of the source of the money and regardless of where the money is located and/or regardless of how it is held. The Plan will also have the first right of recovery out of any recovery or settlement amount you're able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of recovery or settlement.

You must promptly execute and deliver any documents relating to settlement of claims, settlement negotiations or litigation when the Plan asks you to so the Plan can exercise its subrogation rights. Also, you or your legal representative must (1) promptly notify the Plan in writing of any settlement negotiations before you enter into any settlement agreement, (2) disclose to the Plan any amount recovered from any person or entity that may be liable and (3) not make any distributions of settlement or judgment proceeds without the Plan's prior written consent. Any waiver, release of liability or other documents executed by you without such written notice to the Plan won't be binding upon the Plan.

Any failure to pay an amount subject to subrogation will be treated as an overpayment of benefits (see "Recovery of Incorrect & Over Payments" below), and the Plan will have the right to recover the amount subject to subrogation plus all costs of collection including attorneys' fees and court costs. The Plan will be entitled to seek equitable relief to preserve or enforce its subrogation rights and will have an equitable lien on amounts subject to the Plan's subrogation rights.

Recovery of Incorrect & Over Payments

If, for any reason including an error on the part of the Claims Administrator, the Claims Administrator pays a benefit that should not have been paid or pays more than the amount that should have been paid under the terms of the Plan ("overpayment"), the Claims Administrator may take action to recover the overpayment. The Claims Administrator may, in its discretion: (1) require that you repay the overpayment, (2) require that the person receiving the payment repay the overpayment, (3) offset (i.e., reduce) future amounts payable to you or on your behalf under the Plan, and/or (4) take such other actions as may be determined by the Claims Administrator and permitted under applicable law. This right does not affect any other right of recovery the Plan

may have with respect to the overpayment. By accepting benefits under the Plan, you and your family members agree to (1) notify the Claims Administrator of any overpayment you're aware of and (2) cooperate in the repayment or recovery of the overpayment.

Non-Assignability of Benefits

Except as otherwise specified in this section, the benefits available under the Plan, and any right to reimbursement or payment arising out of those benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You cannot sell, assign, pledge, transfer or grant any interest in or to these benefits, or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against the Plan and imposes no duty or obligation on the Plan.. If you receive Covered Services from an out-of-network Provider and wish to assign your payment to the Provider, you or the Provider may submit the documents requesting assignment to the Claims Administrator who, the Claims Administrator will, in its discretion, determine whether to honor the assignment and, if approved, remit any payment due directly to the Provider.

No Surprises Act

The federal “No Surprises Act” protects you from surprise balance bills from out-of-network Providers in certain situations.

- • **Emergencies:** When you receive emergency care from out-of-network Providers, your financial responsibility will be determined in the same way as if you received the care from network Providers. Also, out-of-network Providers can’t Balance Bill you for the difference between the Allowed Amount and the billed charge.
- • **Non-emergency service at network facilities:** The same emergencies rule above applies if you receive services from out-of-network Providers while you are at a network facility, such as a hospital or outpatient surgery center, unless the Provider gives you a legally-required notice and you give consent in accordance with the law. If you give this consent, you will pay the out-of-network Cost Share and any Balance Bill, and the No Surprises Act dispute process won’t apply.
- • **Disputes:** If out-of-network Providers want to dispute the amount the Claims Administrator pays them, they are required to resolve the dispute with the Claims Administrator. As long as you pay your required cost-share amount, they can’t collect any other amounts from you.

If you feel that you have incorrectly received a Balance Bill, you can contact the following agency to dispute the bill.
Consumer Affairs Division
Arizona Department of Insurance and Financial Institutions
100 North 15th Avenue, Suite 261
Phoenix, Arizona 85007-2624
Phone: (602) 364-2499
Email: insurance.consumers@difi.az.gov
Website: https://difi.az.gov/complaint

Your ERISA & Privacy Rights

Statement of ERISA Rights

Your Rights

As a participant in the Plan, you're entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all plan participants (i.e., members) are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including any insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Receive, upon request, a copy of the procedures used by the Plan for determining and processing qualified medical child support orders.
- Continue medical and prescription drug coverage for yourself and/or your eligible dependents if there's a loss of coverage under the Plan as a result of a qualifying event. You will have to pay the entire cost of coverage (see "COBRA Coverage" in the **End of Regular Coverage & COBRA Continuation Coverage** section, as well as the separate COBRA notice(s) you'll receive).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation and administration of the Plan and the benefits made available under the Plan. These people, called "fiduciaries", have a duty to operate/administer the Plan and benefits prudently and in the interest of you and other participants. No one, including your employer or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining a benefit under the Plan or exercising your rights under ERISA.

How to Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, or if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may use the Plan's internal claim procedures (see "Internal Claim Procedures" in the **Plan Administration** section). After you've exhausted the Plan's internal claim procedures, you may file suit in a state or federal court if the suit is filed within the required time period (see "Requirement to Exhaust Internal Claim Procedures & Statute of Limitations" under "Internal Claim Procedures" in the **Plan Administration** section).

If it should happen that plan fiduciaries misuse the Plan's money or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have general questions regarding the Plan (including, for example, whether you're eligible to participate in the Plan), you should contact the Plan Administrator. If you have questions regarding eligibility for a particular benefit and/or the amount of benefits payable, you should contact the Claims Administrator.

If you have any questions about this Statement of ERISA Rights or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator or Claims Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by visiting their website at www.dol.gov/agencies/ebsa.

HIPAA Privacy & Security Rules

Your Rights

The HIPAA Privacy and Security Rules require that the Plan maintain the privacy and security of your protected health information ("PHI"). Your PHI generally includes information that:

- is related to your past, present or future health condition
- individually identifies you or could reasonably be used to identify you **and**
- is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form

Your PHI does not include health information contained in employment records held by your employer in its role as your employer, such as health information relating to a disability, work-related injury/illness, or leave.

The Plan will use and disclose your PHI only as permitted by the HIPAA Privacy and Security Rules. Also, you have certain rights, such at the right to inspect and request a copy of your PHI. The Plan has a notice of privacy rights which more fully explains the Plan's obligations and your rights. The Plan will automatically send you a copy of this notice, but you can also contact the Plan Administrator to request a copy.

Plan Sponsor's Obligations

Conditions for Receiving PHI

As a condition of the Plan Sponsor's or Swift's receiving PHI from the Plan in accordance with the HIPAA Privacy and Security Rules, the Plan Sponsor and Swift agree to: (1) not use or further disclose PHI other than as permitted or required by this document or by law, (2) ensure that any agents, including subcontractors, to whom the Plan Sponsor or Swift provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor and Swift with respect to the PHI, (3) not use or disclose PHI for employment-related actions and decisions, (4) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor or Swift unless authorized by the individual or permitted and disclosed in the Plan's notice of privacy practices, (5) report to the Plan any security incident of which they become aware, (6) make PHI available in accordance 45 C.F.R. §164.524 (relating to access of individuals to their own PHI), (7) make PHI available for amendment and incorporate any amendments to PHI in accordance 45 C.F.R. §164.526, (8) make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528, (9) make their internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the HIPAA Privacy and Security Rules, (10) if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor or Swift maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible), (11) restrict the access to and use of

PHI by the persons described below under "Adequate Separation" to the functions performed by those persons with respect to the administration of the Plan in connection with their duties for the Plan Sponsor or Swift, (12) provide a mechanism for resolving any issues of noncompliance by the persons described below under "Adequate Separation", including disciplinary sanctions, and (13) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI that is maintained or transmitted in an electronic format.

Adequate Separation

To ensure adequate separation between the Plan Sponsor (or Swift) and the Plan, only certain designated employees within the following categories of employees may be given access to PHI: the Plan's privacy officer, Benefits Department personnel, HR Compliance personnel, Information Technology Department personnel, and Legal Department personnel.

How to Enforce Your Rights & Assistance with Your Questions

For information about how to enforce your rights or get assistance with your questions, please refer to the Plan's notice of privacy practices. As indicated above, the Plan will automatically send you a copy of this notice, but you can also contact the Plan Administrator to request a copy.

Other Important Information

Identifying Information

Name of Plan

Swift Transportation Self-Funded Medical & Prescription Drug Plan, which is a component of the Swift Transportation Cafeteria Plan

Type of Plan

Welfare benefit plan, providing self-funded medical and prescription drug benefits

Plan Year

January 1 - December 31; plan records are kept on a plan year basis

Plan Number

502

Plan Sponsorship & Administration

Plan Sponsor

Knight-Swift Transportation Holdings Inc.
2200 S. 75th Avenue
Phoenix, AZ 85043
(602) 269-9700
EIN 20-5589597

The Plan Sponsor maintains the Plan solely for the benefit of the Participating Employers' eligible employees and their eligible dependents. Non-Participating Employers' employees (and their dependents) are not eligible to participate in the Plan.

Participating Employers

Swift Transportation Co., LLC and all related companies which are not Non-Participating Employers (as defined in the Swift Transportation Cafeteria Plan)

A transfer of employment from one Participating Employer to another will not affect an employee's participation in the Plan so long as the employee otherwise remains eligible to participate. There will be no duplication of benefits because of employment by more than one Participating Employer.

Plan Administrator

Director of Benefits of Swift Transportation Co., LLC
2200 S. 75th Avenue
Phoenix, AZ 85043
(623) 907-7453

Claims Administrator

For Medical Benefits (other than the Chiropractic Services Benefit)

Contract administration per an administrative services agreement with:

Blue Cross Blue Shield of Arizona (BCBSAZ)
P.O. Box 13466
Phoenix, AZ 85002-3466
(855) 845-1883

For the Chiropractic Services Benefit

Contract administration (per an administrative services agreement with BCBSAZ) by BCBSAZ's vendor:

American Specialty Health Networks, Inc.
PO Box 509001
San Diego, CA 92150-9001
(800) 678-9133

For Prescription Drug Benefits

Contract administration per an administrative services agreement with:

CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196
(888) 766-5513

The Claims Administrators do not insure or guarantee any of the benefits payable under the Plan.

COBRA Administrator

PayFlex Systems USA, Inc.
PO Box 953374
St. Louis, MO 63195-3374
(800) 359-3921

Additional Information

Service of Process

If you have to bring legal action against the Plan for any reason, legal process can be served on the Plan Administrator c/o:

Knight-Swift Transportation Holdings, Inc.
Attn: General Counsel
2200 S. 75th Avenue
Phoenix, AZ 85043

You cannot bring a legal action unless and until you first exhaust the Plan's internal claim procedures, in which case you must bring the legal action within the statute of limitations (see "Internal Claim Procedures" in the **Plan Administration** section).

Self-Funded Status

The Plan is self-funded. This means there's no insurance company that guarantees or is responsible for paying benefits payable under Plan. Rather, Swift is responsible for paying all of the benefits payable under the Plan, and benefits will be paid from your premiums and then out of Swift's general assets. Swift may also use your premiums (then its general assets) to pay administration expenses.

Swift and the Plan Sponsor are not required to set aside or segregate any of their assets to pay for benefits under the Plan, and your participation in the Plan doesn't give you any particular right to any of their assets. The Plan Sponsor (or Swift) may obtain insurance to help Swift meet its obligation to pay benefits payable under the Plan. In that case, the Plan Sponsor (or Swift) will be the insured party, the insurer will not guarantee or insure benefits under the Plan, the policy will not be a plan asset, and you won't have any rights to or claims against the insurer or the policy.

Limitation of Rights

Neither the establishment nor the existence of the Plan gives any person any legal or equitable right against the Plan, Plan Sponsor, Plan Administrator, Claims Administrator, or Participating Employers, except as required by law or as expressly provided herein. The Plan is not an employment contract. Participation in the Plan doesn't give any person the right to continued employment or prohibit changes to any person's employment, even if the change affects eligibility for coverage under the Plan.

Third-Party Beneficiaries

The provisions of the Plan are only for the benefit of those covered under the Plan, and then only for the level of coverage in which the person is actually enrolled. Except as may be expressly set forth in this document, no third party may seek to enforce or benefit from any provisions of the Plan.

Amendment & Termination

While the Plan Sponsor and Swift intend to maintain the Plan for the indefinite future, they reserve the right to amend or terminate the Plan, in whole or in part, at any time in their sole discretion and retroactively to the extent permitted by applicable law. Any such amendment may change any of the terms of the Plan (for example, the eligibility requirements, cost-sharing requirements, or level(s) of coverage may all be changed). In all cases, an amendment or termination must be in made in writing because the Plan cannot be amended or terminated by verbal statements. The Plan Sponsor's or Swift's decision to amend or terminate the Plan is a business decision, not a fiduciary decision.

There's no guarantee of continued benefits and no vested rights to benefits based on the provisions of the Plan before the effective date of an amendment or termination. This means that, if the Plan is amended, benefits for claims incurred on or after the date the amendment becomes effective will be payable in accordance with the amended Plan provisions. If the Plan is terminated, benefits will be payable only for claims incurred before the date the termination becomes effective and those claims will be payable in accordance with the Plan provisions then in effect.

Construction, Governing Law & Severability

This document constitutes the entire Plan. Any written or oral statement (other than a written amendment made in accordance with the terms of the Plan) that is contrary to the provisions of this document is invalid and no person may rely on any such statement.

Unless otherwise clearly indicated by the context, masculine terminology used in the Plan includes the feminine gender and the definition of any term in the singular includes the plural. The captions of sections and subsections are for convenience only and shall not control or affect the meaning or construction of any of its provisions.

To the extent not preempted by federal law (such as ERISA), the Plan shall be construed and enforced according to the laws (other than conflict of laws) of the State of Arizona.

If any provision of the Plan is held invalid or illegal for any reason, that provision shall not affect the remaining parts of the Plan. Rather, the Plan shall be construed and enforced as if the invalid or illegal provision had not been included. In addition, the Plan Sponsor and Swift each have the right to correct or remedy any questions of invalidity or illegality by amendment.

Defined Terms

"Allowed amount" means the total amount of reimbursement allocated to a covered service and includes both the Plan's payment and the member's cost-share payment. The Claims Administrator calculates the applicable deductible and coinsurance based on the allowed amount, less any precertification charges. The Claims Administrator uses the allowed amount to accumulate toward any applicable out-of-pocket maximum. The allowed amount does not include any balance bills. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services. If the allowed amount is based on a fee schedule, a change to the fee schedule may result in higher member cost-share. The following tables show how the Claims Administrator determines the allowed amount for the Value and Core levels of coverage and for the Premium level of coverage.

Table for Value & Core Levels of Coverage

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule with adjustments for any negotiated contractual arrangements and certain claim editing procedures and pricing guidelines
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements
Providers contracted with another Blue Cross or Blue Shield ("BCBS")	Emergency and non-emergency	Lesser of the provider's billed charges or the price the local BCBS has negotiated with the provider
Noncontracted providers	Non-emergency Emergency	Lesser of the provider's billed charges or either the applicable BCBSAZ fee schedule with adjustments for certain claim editing procedures and pricing guidelines or the local BCBS nonparticipating provider local payment, whichever is applicable.

Noncontracted ground ambulance providers including providers contracted with another BCBSAZ network, but not contacted a plan network provider for this benefit plan, in and outside Arizona	Non-emergency and non-ancillary	Based on the ambulance provider's billed charge.
Noncontracted providers in an in-network facility (in and outside Arizona)	Emergency	The Qualifying Payment Amount , as defined by federal law, is the Allowed Amount. If you sign a consent for a noncontracted provider to perform services at an in-network facility, you are responsible for the difference between the Qualifying Payment Amount and the provider's billed charges.
Noncontracted providers, excluding air ambulance, in and outside Arizona	Emergency and non-emergency	The Qualifying Payment Amount , as defined by federal law, is the Allowed Amount.
Noncontracted air ambulance providers in and outside Arizona		Lesser of the provider's Billed Charges or the applicable BCBSAZ fee Schedule, with adjustments for certain claim editing procedures and pricing guidelines' The member's Cost share will be based on the lesser of the provider's billed charges or the Qualifying Payment Amount as defined by federal law.
Noncontracted providers	Emergency	Billed charges

Table for Premium Level of Coverage

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ as in-network	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the applicable Plan Network fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures and pricing guidelines
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements
Providers contracted with another Blue Cross or Blue Shield ("BCBS")	Emergency and non-emergency	Lesser of the provider's billed charges or the price the local BCBS has negotiated with the provider
Noncontracted providers, excluding air ambulance, in and outside Arizona	Emergency	The Qualifying Payment Amount, as defined by federal law, is the Allowed Amount.
Noncontracted ground ambulance in and outside Arizona	Emergency	The billed charges from the provider are the Allowed Amount
Noncontracted air ambulance in and outside Arizona	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures and pricing guidelines The member's Cost share will be based on the lesser of the provider's billed charges or the Qualifying Payment Amount as defined by federal law

Noncontracted providers in a network facility in and outside Arizona, including providers contracted with BCBSAZ as PPO or HMO providers but who are not in the Plan's network	Non-emergency and non-ancillary	The Qualifying Payment Amount, as defined by federal law, is the Allowed Amount. If you sign a consent for a noncontracted provider to perform services at a network facility, you are responsible for the difference between the Qualifying Payment Amount and the provider's billed charges.

"Ancillary Services" are services that include emergency medicine, anesthesiology, pathology, radiology, neonatology certain laboratory services, or as otherwise required by law.

"Balance bill" means an amount you may be charged for the difference between a noncontracted provider's billed charges and the Plan's allowed amount or the amount you may be charged for services in excess of a benefit limit or maximum.

"Bariatric surgery" means a surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric surgery also includes any revisions to a bariatric surgical procedure.

"**Behavioral Health Benefits**" means benefits for services to treat behavioral health conditions that are classified as behavioral health conditions based on generally recognized independent standards of current mental health, including the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or the most current version of the International Classification of Diseases (ICD).

"BCBS" means organizations within the Blue Cross and Blue Shield Association whose networks may be included as in-network for purposes of the Plan and whose contracted providers may be included as out-of-network participating-only providers (see the **Medical Providers** section). BCBS is an independent contractor and not an agent, partner, or joint-venture of the Plan Sponsor or Participating Employers. To the extent required by the context, references to "BCBS" include BCBSAZ.

"BCBSAZ" means Blue Cross Blue Shield of Arizona, which is an independent licensee of the Blue Cross and Blue Shield Association. To the extent required by the context, references to "BCBSAZ" include a contracted vender when performing functions on behalf of BCBSAZ. BCBSAZ is an independent contractor and not an agent, partner, or joint-venture of the Plan Sponsor or Participating Employers.

"Billed charges" means (1) for a provider that has a participation agreement governing the amount of reimbursement, the amount the provider routinely charges for a service, or (2) for a provider that has no participation agreement governing the amount of reimbursement, the lowest amount that the provider is willing to accept as payment for a service.

"Blue Distinction®" means a national designation awarded by Blue Cross Blue Shield (BCBS) plans to recognize providers that demonstrate expertise in delivering quality specialty care – safely, effectively, and cost-efficiently.

"Brand name drug" means a prescription drug which is protected by trademark registration.

"Claims Administrator" means the applicable Claims Administrator identified in "Plan Sponsorship & Administration" in the **Other Important Information** section.

"Chiropractic Benefits Administrator" means American Specialty Health Networks, Inc., the independent company that administers chiropractic benefits for BCBSAZ. The Chiropractic Benefits Administrator develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

"Cosmetic" means surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including but not limited to, and except as otherwise required by applicable law, those

surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition or function.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, including the regulations and other applicable guidance issued thereunder.

"COBRA Administrator" means the COBRA Administrator identified in "Plan Sponsorship & Administration" in the **Other Important Information** section.

"COBRA coverage" means the limited continuation coverage to which a qualified beneficiary is entitled (under COBRA) if coverage would otherwise end due to a qualifying event (see "COBRA Continuation Coverage" in the **End of Coverage & COBRA Continuation Coverage** section).

"Core", in reference to a level of coverage, means the Core level of coverage (see "Levels of Coverage" in the **Understanding Your Plan"** section).

"Cost-share" means the member's financial obligation for a covered service or prescription drug, which is in addition to any premiums the member pays for coverage. Cost-share may include one or more of the following: balance bill, deductible, copay, coinsurance, and precertification charges (see "Your Cost-Share & Other Payments" in the **Prescription Drug Benefits** section and the **Medical Benefits Overview** section).

"Coinsurance" means a percentage you may be responsible for paying for certain covered services and prescription drugs (see "Your Cost-Share & Other Payments" in the **Prescription Drug Benefits** section and the **Medical Benefits Overview** section).

"Copay" means a fee you may be responsible for paying at the time you receive services (see "Your Cost-Share & Other Payments" in the **Prescription Drug Benefits** section and the **Medical Benefits Overview** section).

"Custodial Care" means health services and other related services that meet any one or more of the following criteria: (1) are for comfort or convenience, (2) do not seek to cure, (3) are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition or other self-care, or (4) are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as an L.P.N., R.N. or licensed therapist.

"Diagnosis Related Grouping" or "DRG" means a method for reimbursing hospitals for inpatient services. A DRG amount can be higher or lower than the actual billed charges because it is based on an average for that grouping of diagnoses and procedures.

"Deductible" means the amount you may have to pay for certain services before the Plan begins to pay its share of the allowed amount for these services (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

"Dependent" means a person eligible for coverage as a dependent, as specified in "Dependents" under "Eligibility" in the **Eligibility & Enrollment** section.

"Domiciliary Care" means a supervised living arrangement in a home-like environment for individuals who are unable to live independently and who need assistance with activities of daily living, such as bathing, dressing and food preparation.

"Eligible provider" means a properly licensed, certified or registered provider listed below, when acting within the scope of their practice and license, or a properly licensed or certified facility listed below, when licensed or certified for the type of procedure and services provided.

Scope of practice is determined by the regulatory oversight agency for each health profession. It means the procedures, actions, and processes that a licensed or certified medical professional is legally allowed to perform based on the individual's specific education and experience, and demonstrated competency. For example, neurosurgery would not be within the scope of practice for a dentist.

ELIGIBLE PROVIDER LIST	
Professional	**Facility Ancillary**
• Acupuncturist • Board Certified Applied Behavioral Analyst (BCABA) • Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (DC) • Doctor of dental surgery (DDS) • Doctor of medical dentistry (DMD) • Doctor of medicine (MD) • Doctor of optometry (OD) • Doctor of osteopathy (DO) • Doctor of podiatry (DPM) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner • Licensed professional counselor • Physician Assistant (PA) • Psychologist (PhD, EdD and PsyD) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long-Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Pain Management Clinic • Rehabilitation Treatment Center (inpatient substance abuse use disorder treatment facility) • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Sub-acute behavioral health facility (including residential treatment) • Urgent Care

"Emergency medical condition" means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that failing to get immediate medical attention would result in serious jeopardy to the patient's life, health or ability to completely recover, serious impairment to a bodily function or part, or permanent disability.

"Employee" means an individual employed by and on the payroll of a Participating Employer.

"Enrollment period" means a period of time during which you may enroll in the Plan and includes the period of time during which you may make a mid-year change (see "Enrollment Procedures" in the **Eligibility & Enrollment** section).

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, including the regulations and other applicable guidance issued thereunder.

"Evidence-based criteria" means the Claims Administrator's medical, pharmaceutical, dental, and administrative criteria, which are based on industry-standard research and technology. These criteria help the Claims Administrator determine whether a service, procedure, medical device, or drug meets the industry standard for medical necessity and/or is a covered benefit. Criteria may include prescription medication or service limitations. The Claims Administrator ensures that evidence-based criteria is reviewed regularly and updated in response to changes and advancements in the healthcare industry. Decisions are based on the evidence-based criteria in effect at the time of service. You can obtain additional information by calling the BCBSAZ customer service number on your ID card. BCBSAZ contracted vendor(s) may establish evidence-based criteria of their own for services the vendor provides or administers pursuant to the vendor's contract with BCBSAZ.

"Experimental or Investigational" means a service or item that the Claims Administrator, in its discretion, determine is experimental or investigational. A service or item will be considered experimental or investigational unless it meets **all** of the following criteria: (1) the service or item must have final approval from the appropriate

governmental regulatory bodies (unless otherwise required by applicable law, final approval of a regulatory body does not, in and of itself, qualify a service or item for coverage) if applicable, (2) the scientific evidence must permit conclusions concerning the effect of the service or item on health outcomes, (3) the service or item must improve the net health outcome, (4) the service or item must be as beneficial as any established alternative, **and** (5) the improvement resulting from the service or item must be attainable outside the investigational setting.

In addition to classifying a service or item as experimental or investigational using the above criteria, the Claims Administrator may also classify the service or item as experimental or investigational if any one or more of the following apply: (1) the service or item cannot be lawfully marketed or used without full (unrestricted) approval of appropriate governmental regulatory bodies and approval for marketing or use has not been given at the time the service or item is submitted for precertification or provided, (2) the provider providing the service or item documents that the service or item is experimental or investigational, or (3) published reports and articles in authoritative (peer-reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis.

"FDA" means the U.S. Food and Drug Administration.

"Fee schedules" mean proprietary schedules of provider fees compiled by BCBSAZ, BCBSAZ's contracted vendors, or a local BCBS (collectively, "BCBS"). BCBS develops proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBS's historical claims experience, pricing information that may be available to BCBS, or information and comments from providers and negotiated contractual arrangements with providers. **BCBS may change its fee schedules at any time without prior notice to members. If the allowed amount is based on a fee schedule, a change to the fee schedule may result in higher member cost-share.**

"Generic drug" means a prescription drug which is not protected by a trademark registration but is produced and sold under the chemical formulation name.

"HIPAA Privacy and Security Rules" means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts 160 and 164, subparts A and E and the Standards for Security of Individually Identifiable Health Information at 45 C.F.R. parts 160 and 164, subparts A and C.

"Ineligible provider" means a provider who is not an eligible provider. Examples of ineligible providers include but aren't limited to acupuncturists and doctors of naturopathy and homeopathy.

"Inpatient residential care" means medical or mental-behavioral care provided in a 24-hour facility licensed by the state in which it is located, and not licensed as a hospital, that offers integrated therapeutic services, educational services and activities of daily living. These services are part of a well-defined, individually tailored, medical or mental-behavioral treatment plan that is clinically appropriate based upon the individual's medical or mental-behavioral needs and is performed in a clinically appropriate facility.

"In-network care" or **"in-network services"** means services provided by an in-network provider.

"In-network provider" means an eligible provider who has contracted with BCBS to furnish supplies or services for a negotiated charge and doesn't include an eligible provider contracted as a participating-only provider. For more information on in-network providers, see "In-Network Providers" in the **Medical Providers** section. For more information about participating-only providers, see "Out-of-Network Providers" in the **Medical Providers** section.

"In-network pharmacy" means a pharmacy which is a party to a contract with CVS Caremark to dispense prescription drugs to persons covered by the Plan, but only while the contract remains in effect and only while the pharmacy dispenses prescription drugs under the terms of its contract with CVS Caremark.

"Long-term maintenance medication" means a medication that is taken regularly for chronic conditions or long-term therapy. For example, medications for managing high blood pressure, asthma, diabetes, or high cholesterol.

"Medicaid Plan" means a Medicaid plan under Title XIX of the Social Security Act.

"Medically or dentally necessary" or **"medical or dental necessity"** means the Claims Administrator, in its sole and absolute discretion, decides whether a service or prescription drug is medically necessary based on the following definition. A medically necessary service is a service that meets **all** of the following requirements: (1) is consistent with the diagnosis or treatment of a symptom, illness, disease or injury, (2) is not primarily for the convenience of a member or a provider, (3) is the most appropriate site, supply or service level that can safely be provided, **and** (4) meets the Claims Administrator's medical necessity guidelines and criteria in effect when the service is precertified or provided. If no such guidelines or criteria are available, the Claims Administrator will base its decision on the judgment and expertise of a medical professional or medical consultant retained by the Claims Administrator.

For Premium medical benefits, the Claims Administrator uses evidence-based criteria to make medically necessary decisions. For Value and Core medical benefits, the Claims Administrator uses the following sources and criteria to make medical necessity decisions, but does not rely on each source for every decision: (1) evidence-based criteria (local medical policy), and (2) Medicare guidelines. You can call the BCBSAZ customer service number on your ID card for additional information on evidence-based criteria.

The Claims Administrator contracts with vendors to administer some or all of the benefits covered under the Plan. These contracted vendors make medical necessity decisions based on their own medical necessity criteria, which are also available to you on request.

"Medical/Surgical Benefits" means benefits for services to treat medical conditions that are classified as medical/surgical based on generally recognized independent standards of current medical practice, including the most current version of the ICD.

"Member" means a person who is enrolled in the Plan.

"Noncontracted provider" means a provider who does not have a contract with BCBS.

"Out-of-network care" or **"out-of-network services"** means services provided by an out-of-network provider.

"Out-of-network pharmacy" means a pharmacy that is not an in-network pharmacy.

"Out-of-network provider" means a provider who is not an in-network provider.

"Participating Employer" means the Participating Employers identified in "Plan Sponsorship & Administration" in the **Other Important Information** section.

"Per diem" means a method of reimbursement based on a negotiated rate per day for payment of covered services provided to a patient in a facility.

"Pharmacy" means an establishment where prescription drugs are legally dispensed.

"Physician" means, for purposes of classifying benefits and member cost-share, a properly licensed M.D., D.O., D.P.M., or D.C.

"Plan" means the Swift Transportation Self-Funded Medical & Prescription Drug Plan, as set forth herein and as may be amended from time to time.

"Plan Administrator" means the Plan Administrator identified in "Plan Sponsorship & Administration" in the **Other Important Information** section.

"Plan Network" means the network of providers contracted with BCBS to provide in-network services to members of this Plan.

"Plan Sponsor" means the Plan Sponsor identified in "Plan Sponsorship & Administration" in the **Other Important Information** section.

"Plan year" means January 1 through December 31.

"Post-service claim" means a claim relating to a service you've already received or a prescription drug you've already filled.

"Pre-service claim" means a claim relating to a service you haven't already received because it's subject to precertification or a prescription drug you haven't already received because it's subject to prior authorization.

"**Precertification**" means the process the Claims Administrator for medical benefits uses to determine coverage for certain benefits.

"Precertification charge" means a charge for not precertifying certain services which reduces the amount payable by the Plan (see "Your Cost-Share & Other Payments" in the **Medical Benefits Overview** section).

"Premium", in reference to a level of coverage, means the Premium level of coverage (see "Levels of Coverage" in the **Understanding Your Plan"** section).

"Prescription" means an order of a provider for a prescription drug, provided he or she has the legal authority to write the order and is acting within the scope of his or her license when writing the order.

"Prescription drug" means any of the following: (1) a drug, biological, compounded prescription or contraceptive device which, by federal law, maybe dispensed only by a prescription and which is required to be labeled: "Caution: Federal Law prohibits dispensing without prescription", (2) an injectable contraceptive drug prescribed to be administered by a paid health care professional, (3) an injectable drug prescribed to be self-administered or administered by someone who is not a paid health care professional (for example, insulin), (4) disposable needles and syringes which are purchased to administer a covered injectable prescription drug, or (5) disposable diabetic supplies.

"Primary Care Provider" or **"PCP"** means a health care professional who is contracted with BCBSAZ or BCBS as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics or any other classification of provider approved as a PCP by BCBSAZ or BCBS. The Plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

"Prior authorization" means the process the Claims Administrator for prescription drug benefits uses to determine coverage for certain prescription drugs.

"Private Duty Nursing" means the provision of continuous skilled 1-on-1 nursing care on an hourly basis by registered nurses (RNs) or licensed practical nurses (LPNs).

"Provider" means any properly licensed, certified or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional.

"Qualified medical child support order" means a court or administrative order which requires you to provide medical coverage for your child and meets ERISA requirements, as determined by the Plan Administrator. If you're not already enrolled and your child must be enrolled per a qualified medical child support order, you must enroll both you and your child. The Plan has detailed procedures for determining whether an order is a qualified child support order and you can request a copy of these procedures, free of charge, from the Plan Administrator.

"Rehabilitation services" means services that help a person restore skills and functioning for daily living lost due to injury or illness.

"Respite Care" means the provision of short-term, temporary relief of the daily routine and stress to provide those who are caring for family members a personal break from their role as caregiver.

"Service" is a generic term meaning some type of health care treatment, test, procedure, supply, medication, technology, device or equipment.

"Specialist" means either a physician or other health care professional who practices in a specific area other than those practiced by Primary Care Providers, or a properly licensed, certified or registered individual health care provider whose practice is limited to providing behavioral health services. For purposes of cost-share, this definition of "specialist" does not apply to dentists. The Plan doesn't require you to obtain an authorization or referral to see a specialist.

"Specialty drug" means a drug used to treat a specific chronic condition.

"State CHIP Plan" means a state child health plan under Title XIX of the Social Security Act.

"Swift" means Swift Transportation Co., LLC and, to the extent required by the context, the other Participating Employers.

"Telehealth Services Administrator" means American Well Corporation, an independent company that is contracted with BCBSAZ to provide contracted providers, an interactive web platform allowing members to interact with providers, and technical support for telehealth services (i.e., BlueCare Anywhere) covered under the Plan.

"Telehealth Services from BlueCare Anywhere" means medical and behavioral health services provided online via video using a computer, tablet, smartphone, or other mobile device through the Telehealth Services Administrator. BlueCare Anywhere is BCBSAZ's telehealth service (see the **Telemedicine Services** benefit in the Description of Medical Benefits section).

'**Telehealth Services from In-Network Providers**" means services delivered through interactive qualified electronic media.

"Urgent care claim" means a claim for services or prescription drugs for which the application of the non-urgent time periods could seriously jeopardize your life, health or ability to regain maximum function **or** in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

"Value", in reference to a level of coverage, means the Value level of coverage (see "Levels of Coverage" in the **Understanding Your Plan"** section).

"You" means an eligible and enrolled employee or, to the extent required by the context, a person enrolled in the Plan.

Value: Cost-Share Summary

This summary describes the cost-share for different services and prescription drugs for members enrolled in the Value level of coverage. If you're not enrolled in Value, please refer to the summary for the level of coverage you're enrolled in. If you don't know what level you're enrolled in, please refer to your ID card.

For additional information about the benefits referred to in this summary, including but not limited to the benefit maximums and limits that apply to certain benefits, please see the **Prescription Drug Benefits** section, **Medical Benefits Overview** section, **Description of Medical Benefits** section, and the **General Exclusions** section.

	VALUE COST-SHARE
Physician Services (office, home, or walk-in clinic)	PCP – $50 copay per member, per provider, per day Specialist – $100 copay per member, per provider, per day
Prescription Drugs – Retail Pharmacy	Generic – $15 copay per 30-day supply Preferred Brand – member pays lesser of 30% coinsurance or $75, per 30-day supply (no deductible) Non-Preferred Brand – member pays lesser of 30% coinsurance or $125, per 30-day supply (no deductible) Specialty – same as preferred brand (if preferred) or non-preferred brand (if not preferred); copay/coinsurance waived for certain specialty drugs if enrolled in PrudentRx Co-Pay Program
Prescription Drugs – Mail Order	Generic – $40 copay per 90-day supply Preferred Brand – member pays lesser of 30% coinsurance or $190, per 90-day supply (no deductible) Non-Preferred Brand – member pays lesser of 30% coinsurance or $315, per 90-day supply (no deductible) Specialty – same as preferred brand (if preferred) or non-preferred brand (if not preferred); copay/coinsurance waived for certain specialty drugs if enrolled in PrudentRx Co-Pay Program
In-Network Calendar-Year Deductible (for medical benefits only)	$2,500 per member, per calendar year $5,000 per family, per calendar year
Out-of-Network Calendar-Year-Deductible (for medical benefits only)	$5,000 per member, per calendar year $10,000 per family, per calendar year
In-Network Coinsurance (for medical benefits only, but see separate coinsurance above for brand name drugs)	Plan pays 70%, member pays 30% of the allowed amount, after meeting deductible. Please see benefits below for the exact cost-share amount.
Out-of-Network Coinsurance (for medical benefits only)	Plan pays 50%, member pays 50% of the Plan's allowed amount, after meeting deductible. Please see benefits below for the exact cost-share amount.
In-Network Out-of-Pocket Maximum (combined for medical benefits and fertility medications covered under the prescription drug benefit)	$8,000 per member, $16,000 per family, per calendar year
Out-of-Network Out-of-Pocket Maximum (for medical benefits only)	$16,000 per member, $32,000 per family, per calendar year

BENEFIT	**VALUE IN-NETWORK COST-SHARE**	**VALUE OUT-OF-NETWORK COST-SHARE**
ACUPUNCTURE	For services received in a physician's office, you pay a PCP copay ($50) or a specialist copay ($100). You pay $2,500 deductible	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	VALUE IN-NETWORK COST-SHARE	VALUE OUT-OF-NETWORK COST-SHARE
	and 30% coinsurance for services received outside a physician's office.	
AMBULANCE SERVICES	You pay $2,500 deductible and 30% coinsurance.	
BEHAVIORAL AND MENTAL HEALTH SERVICES (Inpatient)	You pay $2,500 deductible and 30% coinsurance for inpatient facility and professional charges.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
BEHAVIORAL AND MENTAL HEALTH SERVICES (Outpatient Facility and Professional Services and Treatment of Autism Spectrum Disorder)	You pay $50 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. You pay $2,500 deductible and 30% coinsurance for services received in locations other than office, home, or walk-in clinics and for intensive outpatient services.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CATARACT SURGERY AND KERATOCONUS	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CHIROPRACTIC SERVICES	You pay $100 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. The copay does not apply if you receive only physical medicine and rehabilitation services and no other covered service during your visit. You pay $2,500 deductible and 30% coinsurance for physical medicine and rehabilitation services and for chiropractic services received in other locations.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CLINICAL TRIALS	You pay $2,500 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($50) or a specialist copay ($100).	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
DENTAL SERVICES BENEFIT – MEDICAL	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
DIABETES AND ASTHMA EDUCATION AND TRAINING	Your cost-share is waived.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS	For services received in a physician's office, you pay a PCP copay ($50) or a specialist copay ($100). You pay $2,500 deductible and 30% coinsurance for services received outside a physician's office. Your cost-share is waived for one FDA-approved	Not covered.

BENEFIT	VALUE IN-NETWORK COST-SHARE	VALUE OUT-OF-NETWORK COST-SHARE
	manual or electric breast pump and breast supplies per member, per calendar year.	
EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)	You pay $2,500 deductible and 30% coinsurance. If you receive emergency services from a noncontracted facility or professional provider, the Claims Administrator will base the allowed amount used to calculate your cost-share on the provider's billed charges. For all non-emergency services following the emergency treatment and stabilization, see the "Physician Services," "Inpatient Hospital," and "Outpatient Services" cost-share sections.	
EOSINOPHILIC GASTROINTESTINAL DISORDER	The deductible is waived. You pay 25% of the Cost for Formula.	
FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)	Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your provider on the claim. Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay $2,500 deductible and 30% coinsurance for FDA-approved male sterilization procedures. Hormonal Contraceptive Methods: Your cost-share is waived for oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" section for benefits. Emergency Contraception: Your cost-share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the "Physician Services" section for benefits. Barrier Contraceptive Methods: Your cost-share is waived for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides. See the "Physician Services" section for benefits.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
HEARING AIDS AND SERVICES	Hearing Aids: You pay $2,500 deductible and 30% coinsurance. Hearing Exams: For services received in a physician's office, you pay a PCP copay ($50) or a specialist copay ($100). You pay $2,500 deductible and 30% coinsurance for	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	VALUE IN-NETWORK COST-SHARE	VALUE OUT-OF-NETWORK COST-SHARE
	services received outside a physician's office.	
HOME HEALTH SERVICES	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
HOSPICE SERVICES	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
INFERTILITY TREATMENT	For services received in a physician's office, member's home, or walk-in clinic visit, you pay a PCP copay ($50) or a specialist copay ($100). You pay $2,500 deductible and 30% coinsurance for services received in locations other than office, home, or walk-in clinics.	Not covered.
INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
INPATIENT HOSPITAL Out-of-network bariatric surgeries are not covered.	You pay $2,500 deductible and 30% coinsurance for most services. You pay a $100 copay per member, per provider, per day for chemotherapy and/radiation therapy services. Your cost-share is waived for facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR)	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
LONG-TERM ACUTE CARE (INPATIENT)	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
MATERNITY Cost-share is waived for maternity services covered under the Preventive Services benefit and delivered by an in-network provider. If you receive these services from an out-of-network provider, the services will be covered through the Maternity benefit and you'll pay the out-of-	Inpatient: You pay $2,500 deductible and 30% coinsurance. Outpatient: You pay one (1) physician visit copay for your first prenatal office or home visit, which covers all physician services included in the physician's Global Charge. You pay one copay, per member, per provider, per day for other physician office or home visits not included in the Global Charge. Your copay will vary depending on whether you see a PCP ($50) or a specialist	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	VALUE IN-NETWORK COST-SHARE	VALUE OUT-OF-NETWORK COST-SHARE
network cost-share. If you receive services from a noncontracted provider, you'll also pay the balance bill. Your cost-share obligations may be affected by the addition of a newborn or adopted child. For example, if you have coverage only for yourself and no dependents, the addition of a child will result in a change from employee-only coverage to family coverage. In that case, you'll be required to meet a family deductible and out-of-pocket maximum. You'll also have to pay an additional premium amount for your dependent's coverage.	($100). You pay $2,500 deductible and 30% coinsurance for professional services in an outpatient facility that are not included in the Global Charge and for outpatient facility charges.	
MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS	The deductible is waived. You pay 30% of the Cost for Medical Foods.	
NEUROPSYCHOLOGICAL AND COGNITIVE TESTING	You pay $2,500 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($50) or a specialist copay ($100).	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
NUTRITIONAL COUNSELING/TRAINING	Your cost-share is waived.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
OUTPATIENT SERVICES You pay $2,500 deductible and 30% coinsurance for all in-network bariatric surgeries. Out-of-network bariatric surgeries are not covered.	Diagnostic Laboratory and/or Radiology Services: You pay a PCP copay ($50) or a specialist copay ($100) for services in a physician's office (copay is waived if you receive only covered laboratory or radiology services during your visit). You pay $2,500 deductible and 30% coinsurance for services provided in other locations. Chemotherapy/Radiation Therapy: You pay a $100 copay per member, per provider, per day. In-network cost-share is waived for professional services provided by a pathologist, dermapathologist or radiologist. Outpatient Facility Services (Including Outpatient Surgery): You pay $2,500 deductible and 30% coinsurance. Your cost-share is waived for facility charges for FDA-approved sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	VALUE IN-NETWORK COST-SHARE	VALUE OUT-OF-NETWORK COST-SHARE
	Sleep Studies: You pay $2,500 deductible and 30% coinsurance.	
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST) SERVICES	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
PHYSICIAN SERVICES If you receive Preventive Services from an in-network physician, your cost-share may be waived.	You pay one copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. Your copay will vary depending on whether you see a PCP ($50) or specialist ($100). Your copay is waived if you only receive the following services and no other covered service during your home or office visit: • Covered allergy injections • Covered immunizations • Covered laboratory services • Covered physical therapy, speech therapy, occupational therapy (PT, OT, ST); these services are subject to in-network deductible and coinsurance • Covered radiology services You pay a $50 copay per member, per provider, per day for transgender counseling services provided during an office, home or walk-in clinic visit. You pay $2,500 deductible and 30% coinsurance for services delivered in locations other than the provider's office, the member's home or a walk-in clinic. Your cost-share will be waived for the following services when the purpose of the procedure is contraception, as documented by your provider on the claim: • Professional physician services for FDA-approved female sterilization procedures, regardless of the location of service. • Professional physician services for fitting, implantation and/or removal (including follow-up care) of FDA-approved contraceptive devices provided during a physician office, home or walk-in clinic visit. • FDA-approved implanted contraceptive devices. • The following FDA-approved generic and brand with no generic equivalent prescription hormonal and barrier	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	VALUE IN-NETWORK COST-SHARE	VALUE OUT-OF-NETWORK COST-SHARE
	contraceptive methods and devices: patches, rings, contraceptive injections, diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides. In-network cost-share is waived for professional services provided by a pathologist, dermapathologist or radiologist. You pay $2,500 deductible and 30% coinsurance for sleep studies in a physician's office.	
POST-MASTECTOMY SERVICES	You pay $2,500 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($50) or a specialist copay ($100).	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
PREGNANCY, TERMINATION	You pay $2,500 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($50) or a specialist copay ($100).	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
PREVENTIVE SERVICES	Your cost-share is waived, regardless of the location where services are provided, if: • You receive one of the services listed in "Benefit Description" under "Preventive Services" in the **Description of Medical Benefits** section; • The procedure code, the diagnosis code or the combination of procedure codes and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive; and • The primary purpose of the visit at which services were provided was for preventive care.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
RECONSTRUCTIVE SURGERY AND SERVICES	You pay $2,500 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($50) or a specialist copay ($100).	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
SKILLED NURSING FACILITY (SNF) SERVICES	You pay $2,500 deductible and 30% coinsurance.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
TELEHEALTH SERVICES	You pay a $50 copay.	Not covered.
TELEMEDICINE SERVICES	You pay the cost-share amount that is applicable to the service being provided via telemedicine. Your location and the	Not covered, except for emergency and urgent services. You pay the cost-share amounts applicable to all services provided via telemedicine. You will

BENEFIT	VALUE IN-NETWORK COST-SHARE	VALUE OUT-OF-NETWORK COST-SHARE
	provider's network status determine the amount of your cost-share.	always pay in-network cost-share for emergency services provided via telemedicine.
TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES Certain facilities are contracted with the Plan Network to provide covered transplants to members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing, certain types of chemotherapy and radiation therapy and other services covered under the Plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with the Plan Network or BCBS to provide those services, you will pay the balance bill plus out-of-network cost-share. If you receive pre-transplant testing or other services associated with the transplant from a Blue Distinction Center for Transplants, you will pay your in-network cost-share.	You pay $2,500 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($50) or a specialist copay ($100). You pay a $100 copay per member, per provider, per day for chemotherapy and/radiation therapy services.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
TRANSPLANT AND GENE THERAPY TRAVEL AND LODGING	Your cost-share is waived.	
URGENT CARE	You pay a $100 copay per member, per provider, per day for services from a provider contracted with the Plan to provide urgent care services.	You pay $5,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Services by any out-of-network ancillary provider will be paid at the in-network level and based on billed charges, when both the facility and operating/attending provider for those services are contracted.

Core: Cost-Share Summary

This summary describes the cost-share for different services and prescription drugs for members enrolled in the Core level of coverage. If you're not enrolled in Core, please refer to the summary for the level of coverage you're enrolled in. If you don't know what level you're enrolled in, please refer to your ID card.

For additional information about the benefits referred to in this summary, including but not limited to the benefit maximums and limits that apply to certain benefits, please see the **Prescription Drug Benefits** section, **Medical Benefits Overview** section, **Description of Medical Benefits** section, and the **General Exclusions** section.

	CORE COST-SHARE
Physician Services (office, home, or walk-in clinic)	PCP – $40 copay per member, per provider, per day Specialist – $80 copay per member, per provider, per day
Prescription Drugs – Retail Pharmacy	Generic – $12 per 30-day supply Preferred Brand – $50 per 30-day supply Non-Preferred Brand – $70 per 30-day supply Specialty – same as preferred brand (if preferred) or non-preferred brand (if not preferred); copay waived for certain specialty drugs if enrolled in PrudentRx Co-Pay Program
Prescription Drugs – Mail Order	Generic – $30 per 90-day supply Preferred Brand – $125 per 90-day supply Non-Preferred Brand – $175 per 90-day supply Specialty – same as preferred brand (if preferred) or non-preferred brand (if not preferred); copay waived for certain specialty drugs if enrolled in PrudentRx Co-Pay Program
In-Network Calendar-Year Deductible (for medical benefits only)	$1,000 per member, per calendar year $2,000 per family, per calendar year
Out-of-Network Calendar-Year-Deductible (for medical benefits only)	$2,000 per member, per calendar year $4,000 per family, per calendar year
In-Network Coinsurance (for medical benefits only)	Plan pays 70%, member pays 30% of the allowed amount, after meeting deductible. Please see benefits below for the exact cost-share amount.
Out-of-Network Coinsurance (for medical benefits only)	Plan pays 50%, member pays 50% of the allowed amount, after meeting deductible. Please see benefits below for the exact cost-share amount.
In-Network Out-of-Pocket Maximum (for medical benefits only)	$6,000 per member, $12,000 per family, per calendar year
Out-of-Network Out-of-Pocket Maximum (combined for medical benefits and fertility medications covered under the prescription drug benefit)	$12,000 per member, $24,000 per family, per calendar year

BENEFIT	**CORE IN-NETWORK COST-SHARE**	**CORE OUT-OF-NETWORK COST-SHARE**
ACUPUNCTURE	For services received in a physician's office, you pay a PCP copay ($40) or a specialist copay ($80). You pay $1,000 deductible and 30% coinsurance for services received outside a physician's office.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
AMBULANCE SERVICES	You pay $1,000 deductible and 30% coinsurance.	
BEHAVIORAL AND MENTAL HEALTH SERVICES (Inpatient)	You pay $1,000 deductible and 30% coinsurance for inpatient facility and professional charges.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	CORE IN-NETWORK COST-SHARE	CORE OUT-OF-NETWORK COST-SHARE
BEHAVIORAL AND MENTAL HEALTH SERVICES (Outpatient Facility and Professional Services and Treatment of Autism Spectrum Disorder)	You pay $40 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. You pay $1,000 deductible and 30% coinsurance for services received in locations other than office, home, or walk-in clinics and for intensive outpatient services.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CATARACT SURGERY AND KERATOCONUS	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CHIROPRACTIC SERVICES	You pay $80 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. The copay does not apply if you receive only physical medicine and rehabilitation services and no other covered service during your visit. You pay $1,000 deductible and 30% coinsurance for physical medicine and rehabilitation services and for chiropractic services received in other locations.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
CLINICAL TRIALS	You pay $1,000 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($40) or a specialist copay ($80).	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
DENTAL SERVICES BENEFIT – MEDICAL	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
DIABETES AND ASTHMA EDUCATION AND TRAINING	Your cost-share is waived.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS	For services received in a physician's office, you pay a PCP copay ($40) or a specialist copay ($80). You pay $1,000 deductible and 30% coinsurance for services received outside a physician's office. Your cost-share is waived for one FDA-approved manual or electric breast pump and breast supplies per member, per calendar year.	Not covered.

BENEFIT	CORE IN-NETWORK COST-SHARE	CORE OUT-OF-NETWORK COST-SHARE
EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)	You pay $1,000 deductible and 30% coinsurance. If you receive emergency services from a noncontracted facility or professional provider, the Claims Administrator will base the allowed amount used to calculate your cost-share on the provider's billed charges. For all non-emergency services following the emergency treatment and stabilization, see the "Physician Services," "Inpatient Hospital," and "Outpatient Services" cost-share sections.	
EOSINOPHILIC GASTROINTESTINAL DISORDER	The deductible is waived. You pay 25% of the Cost for Formula.	
FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)	Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your provider on the claim. Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay $1,000 deductible and 30% coinsurance for FDA-approved male sterilization procedures. Hormonal Contraceptive Methods: Your cost-share is waived for oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" section for benefits. Emergency Contraception: Your cost-share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the "Physician Services" section for benefits. Barrier Contraceptive Methods: Your cost-share is waived for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides. See the "Physician Services" section for benefits.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
HEARING AIDS AND SERVICES	Hearing Aids: You pay $1,000 deductible and 30% coinsurance. Hearing Exams: For services received in a physician's office, you pay a PCP copay ($40) or a specialist copay ($80). You pay $1,000 deductible and 30% coinsurance for services received outside a physician's office.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
HOME HEALTH SERVICES	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	CORE IN-NETWORK COST-SHARE	CORE OUT-OF-NETWORK COST-SHARE
HOSPICE SERVICES	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
INFERTILITY TREATMENT	For services received in a physician's office, member's home, or walk-in clinic visit, you pay a PCP copay ($40) or a specialist copay ($80). You pay $1,000 deductible and 30% coinsurance for services received in locations other than office, home, or walk-in clinics.	Not covered.
INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
INPATIENT HOSPITAL Out-of-network bariatric surgeries are not covered.	You pay $1,000 deductible and 30% coinsurance for most services. You pay an $80 copay per member, per provider, per day for chemotherapy and/or radiation therapy services. Your cost-share is waived for facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR)	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
LONG-TERM ACUTE CARE (INPATIENT)	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
MATERNITY Cost-share is waived for maternity services covered under the Preventive Services benefit and delivered by an in-network provider. If you receive these services from an out-of-network provider, the services will be covered through the Maternity benefit and you'll pay the out-of-network cost-share. If you receive services from a noncontracted provider, you'll also pay the balance bill. Your cost-share obligations may be affected by the addition of a newborn or adopted child. For example, if you have coverage only for yourself and no dependents, the addition of a child will result in a change from employee-only	Inpatient: You pay $1,000 deductible and 30% coinsurance. Outpatient: You pay one (1) physician visit copay for your first prenatal office or home visit, which covers all physician services included in the physician's Global Charge. You pay one copay, per member, per provider, per day for other physician office or home visits not included in the Global Charge. Your copay will vary depending on whether you see a PCP ($40) or a specialist ($80). You pay $1,000 deductible and 30% coinsurance for professional services in an outpatient facility that are not included in the Global Charge and for outpatient facility charges.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	CORE IN-NETWORK COST-SHARE	CORE OUT-OF-NETWORK COST-SHARE
coverage to family coverage. In that case, you'll be required to meet a family deductible and out-of-pocket maximum. You'll also have to pay an additional premium amount for your dependent's coverage.		
MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS	The deductible is waived. You pay 30% of the Cost for Medical Foods.	
NEUROPSYCHOLOGICAL AND COGNITIVE TESTING	You pay $1,000 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($40) or a specialist copay ($80).	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
NUTRITIONAL COUNSELING/TRAINING	Your cost-share is waived.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
OUTPATIENT SERVICES You pay $1,000 deductible and 30% coinsurance for all in-network bariatric surgeries. Out-of-network bariatric surgeries are not covered.	Diagnostic Laboratory and/or Radiology Services: You pay a PCP copay ($40) or a specialist copay ($80) for services in a physician's office (copay is waived if you receive only covered laboratory or radiology services during your visit). You pay $1,000 deductible and 30% coinsurance for services provided in other locations. Chemotherapy/Radiation Therapy: You pay an $80 copay per member, per provider, per day. In-network cost-share is waived for professional services provided by a pathologist, dermapathologist or radiologist. Outpatient Facility Services (Including Outpatient Surgery): You pay $1,000 deductible and 30% coinsurance. Your cost-share is waived for facility charges for FDA-approved sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. Sleep Studies: You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST) SERVICES	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
PHYSICIAN SERVICES	You pay one copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. Your copay will vary depending on whether you see a PCP ($40) or specialist	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	CORE IN-NETWORK COST-SHARE	CORE OUT-OF-NETWORK COST-SHARE
If you receive Preventive Services from an in-network physician, your cost-share may be waived.	($80). Your copay is waived if you only receive the following services and no other covered service during your home or office visit: • Covered allergy injections • Covered immunizations • Covered laboratory services • Covered physical therapy, speech therapy, occupational therapy (PT, OT, ST); these services are subject to in-network deductible and coinsurance • Covered radiology services You pay a $40 copay per member, per provider, per day for transgender counseling services provided during an office, home or walk-in clinic visit. You pay $1,000 deductible and 30% coinsurance for services delivered in locations other than the provider's office, the member's home or a walk-in clinic. Your cost-share will be waived for the following services when the purpose of the procedure is contraception, as documented by your provider on the claim: • Professional physician services for FDA-approved female sterilization procedures, regardless of the location of service. • Professional physician services for fitting, implantation and/or removal (including follow-up care) of FDA-approved contraceptive devices provided during a physician office, home or walk-in clinic visit. • FDA-approved implanted contraceptive devices. • The following FDA-approved generic and brand with no generic equivalent prescription hormonal and barrier contraceptive methods and devices: patches, rings, contraceptive injections, diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides. In-network cost-share is waived for professional services provided by a pathologist, dermapathologist or radiologist. You pay $1,000 deductible and 30% coinsurance for sleep studies in a physician's office.	
POST-MASTECTOMY SERVICES	You pay $1,000 deductible and 30% coinsurance for professional services	You pay $2,000 deductible and 50% coinsurance. If you receive services from

BENEFIT	CORE IN-NETWORK COST-SHARE	CORE OUT-OF-NETWORK COST-SHARE
	provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($40) or a specialist copay ($80).	a noncontracted provider, you also pay the balance bill.
PREGNANCY, TERMINATION	You pay $1,000 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($40) or a specialist copay ($80).	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
PREVENTIVE SERVICES	Your cost-share is waived, regardless of the location where services are provided, if: • You receive one of the services listed in "Benefit Description" under "Preventive Services" in the **Description of Medical Benefits** section; • The procedure code, the diagnosis code or the combination of procedure codes and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive; and • The primary purpose of the visit at which services were provided was for preventive care.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
RECONSTRUCTIVE SURGERY AND SERVICES	You pay $1,000 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($40) or a specialist copay ($80).	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
SKILLED NURSING FACILITY (SNF) SERVICES	You pay $1,000 deductible and 30% coinsurance.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.
TELEHEALTH SERVICES	You pay a $40 copay.	Not covered.
TELEMEDICINE SERVICES	You pay the cost-share amount that is applicable to the service being provided via telemedicine. Your location and the provider's network status determine the amount of your cost-share.	Not covered, except for emergency and urgent services. You pay the cost-share amounts applicable to all services provided via telemedicine. You will always pay in-network cost-share for emergency services provided via telemedicine.
TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES Certain facilities are contracted with the Plan Network to provide covered transplants to members. Not all such facilities are contracted to provide services related to a covered transplant, such as pre-transplant testing,	You pay $1,000 deductible and 30% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($40) or a specialist copay ($80). You pay an $80 copay per member, per provider, per day for chemotherapy and/radiation therapy services.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

BENEFIT	CORE IN-NETWORK COST-SHARE	CORE OUT-OF-NETWORK COST-SHARE
certain types of chemotherapy and radiation therapy and other services covered under the Plan. If you receive pre-transplant testing or other services associated with the transplant from a facility that is not contracted with the Plan Network or BCBS to provide those services, you will pay the balance bill plus out-of-network cost-share. If you receive pre-transplant testing or other services associated with the transplant from a Blue Distinction Center for Transplants, you will pay your in-network cost-share.		
TRANSPLANT AND GENE THERAPY TRAVEL AND LODGING	Your cost-share is waived.	
URGENT CARE	You pay an $80 copay per member, per provider, per day for services from a provider contracted with the Plan to provided urgent care services.	You pay $2,000 deductible and 50% coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Services by any out-of-network ancillary provider will be paid at the in-network level and based on billed charges, when both the facility and operating/attending provider for those services are contracted.

Premium: Cost-Share Summary

This summary describes the cost-share for different services and prescription drugs for members enrolled in the Premium level of coverage. If you're not enrolled in Premium, please refer to the summary for the level of coverage you're enrolled in. If you don't know what level you're enrolled in, please refer to your ID card.

The Premium level of coverage does not include (i.e., does not cover) out-of-network services, except in the case of the following benefits: Ambulance Services, Emergency (Professional and Facility Charges), Eosinophilic Gastrointestinal Disorder, Medical Foods for Inherited Metabolic Disorders, and Telemedicine Services (but only if an emergency or urgent). For additional information about these benefits and the other benefits referred to in this summary, including but not limited to the benefit maximums and limits that apply to certain benefits, please see the **Prescription Drug Benefits** section, **Medical Benefits Overview** section, **Description of Medical Benefits** section, and the **General Exclusions** section.

	PREMIUM COST-SHARE
Physician Services (office, home, or walk-in clinic)	PCP – $30 copay per member, per provider, per day Specialist – $60 copay per member, per provider, per day
Prescription Drugs – Retail Pharmacy	Generic – $10 copay per 30-day supply Preferred Brand – $40 copay per 30-day supply Non-Preferred Brand – $60 copay per 30-day supply Specialty – same as preferred brand (if preferred) or non-preferred brand (if not preferred); copay waived for certain specialty drugs if enrolled in PrudentRx Co-Pay Program
Prescription Drugs – Mail Order	Generic – $25 copay per 90-day supply Preferred Brand – $100 copay per 90-day supply Non-Preferred Brand – $150 copay per 90-day supply Specialty – same as preferred brand (if preferred) or non-preferred brand (if not preferred); copay waived for certain specialty drugs if enrolled in PrudentRx Co-Pay Program
Calendar-Year Deductible (for medical benefits only)	$800 per member, per calendar year $1,600 per family, per calendar year
Coinsurance (for medical benefits only)	Plan pays 75%, member pays 25% of the allowed amount, after meeting deductible. Please see benefits below for the exact cost-share amount.
Out-of-Pocket Maximum (combined for medical benefits and fertility medications covered under the prescription drug benefit)	$4,000 per member, $8,000 per family, per calendar year

BENEFIT	**PREMIUM COST-SHARE**
ACUPUNCTURE	For services received in a physician's office, you pay a PCP copay ($30) or a specialist copay ($60). You pay $800 deductible and 25% coinsurance for services received outside a physician's office.
AMBULANCE SERVICES	You pay $800 deductible and 25% coinsurance.
BEHAVIORAL AND MENTAL HEALTH SERVICES (Inpatient)	You pay $800 deductible and 25% coinsurance for inpatient facility and professional charges.
BEHAVIORAL AND MENTAL HEALTH SERVICES (Outpatient Facility and Professional Services and Treatment of Autism Spectrum Disorder)	You pay a $30 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. You pay $800 deductible and 25% coinsurance for services received in locations other than office, home, or walk-in clinics and for intensive outpatient services.

BENEFIT	PREMIUM COST-SHARE
CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES	You pay $800 deductible and 25% coinsurance.
CATARACT SURGERY AND KERATOCONUS	You pay $800 deductible and 25% coinsurance.
CHIROPRACTIC SERVICES	You pay a $60 copay per member, per provider, per day for services provided during an office, home, or walk-in clinic visit. The copay does not apply if you receive only physical medicine and rehabilitation services and no other covered service during your visit. You pay $800 deductible and 25% coinsurance for physical medicine and rehabilitation services and for chiropractic services received in other locations.
CLINICAL TRIALS	You pay $800 deductible and 25% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($30) or a specialist copay ($60).
DENTAL SERVICES BENEFIT – MEDICAL	You pay $800 deductible and 25% coinsurance.
DIABETES AND ASTHMA EDUCATION AND TRAINING	Your cost-share is waived.
DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS	For services received in a physician's office, you pay a PCP copay ($30) or a specialist copay ($60). You pay $800 deductible and 25% coinsurance for services received outside a physician's office. Your cost-share is waived for one FDA-approved manual or electric breast pump and breast supplies per member, per calendar year.
EMERGENCY (PROFESSIONAL AND FACILITY CHARGES)	You pay $800 deductible and 25% coinsurance. If you receive emergency services from a noncontracted facility or professional provider, the Claims Administrator will base the allowed amount used to calculate your cost-share on the provider's billed charges. For all non-emergency services following the emergency treatment and stabilization, see the "Physician Services," "Inpatient Hospital," and "Outpatient Services" cost-share sections.
EOSINOPHILIC GASTROINTESTINAL DISORDER	The deductible is waived. You pay 25% of the Cost for Formula.
FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)	Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your provider on the claim. Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay $800 deductible and 25% coinsurance for FDA-approved male sterilization procedures. Hormonal Contraceptive Methods: Your cost-share is waived for oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" section for benefits. Emergency Contraception: Your cost-share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the "Physician Services" section for benefits. Barrier Contraceptive Methods: Your cost-share is waived for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides. See the "Physician Services" section for benefits.

BENEFIT	PREMIUM COST-SHARE
HEARING AIDS AND SERVICES	Hearing Aids: You pay $800 deductible and 25% coinsurance. Hearing Exams: For services received in a physician's office, you pay a PCP copay ($30) or a specialist copay ($60). You pay $800 deductible and 25% coinsurance for services received outside a physician's office.
HOME HEALTH SERVICES	You pay $800 deductible and 25% coinsurance.
HOSPICE SERVICES	You pay $800 deductible and 25% coinsurance.
INFERTILITY TREATMENT	For services received in a physician's office, member's home, or walk-in clinic visit, you pay a PCP copay ($30) or a specialist copay ($60). You pay $800 deductible and 25% coinsurance for services received in locations other than office, home, or walk-in clinics.
INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES	You pay $800 deductible and 25% coinsurance.
INPATIENT HOSPITAL	You pay $800 deductible and 25% coinsurance. You pay a $60 copay per member, per provider, per day for chemotherapy and/or radiation therapy services. Your cost-share is waived for facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.
INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR)	You pay $800 deductible and 25% coinsurance.
LONG-TERM ACUTE CARE (INPATIENT)	You pay $800 deductible and 25% coinsurance.
MATERNITY Cost-share is waived for maternity services covered under the Preventive Services benefit. Your cost-share obligations may be affected by the addition of a newborn or adopted child. For example, if you have coverage only for yourself and no dependents, the addition of a child will result in a change from employee-only coverage to family coverage. In that case, you'll be required to meet a family deductible and out-of-pocket maximum. You'll also have to pay an additional premium amount for your dependent's coverage.	Inpatient: You pay $800 deductible and 25% coinsurance. Outpatient: You pay one (1) physician visit copay for your first prenatal office or home visit, which covers all physician services included in the physician's Global Charge. You pay one copay, per member, per provider, per day for other physician office or home visits not included in the Global Charge. Your copay will vary depending on whether you see a PCP ($30) or a specialist ($60). You pay $800 deductible and 25% coinsurance for professional services in an outpatient facility that are not included in the Global Charge and for outpatient facility charges.
MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS	The deductible is waived. You pay 25% of the Cost for Medical Foods.
NEUROPSYCHOLOGICAL AND COGNITIVE TESTING	You pay $800 deductible and 25% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($30) or a specialist copay ($60).

BENEFIT	PREMIUM COST-SHARE
NUTRITIONAL COUNSELING/TRAINING	Your cost-share is waived.
OUTPATIENT SERVICES	Diagnostic Laboratory and Radiology Services: You pay a PCP copay ($30) or a specialist copay ($60) for services in a physician's office (copay is waived if you receive only covered laboratory or radiology services during your visit). You pay $800 deductible and 25% coinsurance for services provided in other locations. Chemotherapy/Radiation Therapy: You pay a $60 copay per member, per provider, per day. Cost-share is waived for professional services provided by a pathologist, dermapathologist or radiologist. Outpatient Facility Services (Including Outpatient Surgery): You pay $800 deductible and 25% coinsurance. Your cost-share is waived for facility charges for FDA-approved sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. Sleep Studies: You pay $800 deductible and 25% coinsurance.
PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST) SERVICES	You pay $800 deductible and 25% coinsurance.
PHYSICIAN SERVICES If you receive Preventive Services from a physician, your cost-share may be waived.	You pay one copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. Your copay will vary depending on whether you see a PCP ($30) or specialist ($60). Your copay is waived if you only receive the following services and no other covered service during your home or office visit: • Covered allergy injections • Covered immunizations • Covered laboratory services • Covered physical therapy, speech therapy, occupational therapy (PT, OT, ST); these services are subject to deductible and coinsurance You pay a $30 copay per member, per provider, per day for transgender counseling services provided during an office, home or walk-in clinic visit. You pay $800 deductible and 25% coinsurance for services delivered in locations other than the provider's office, the member's home or a walk-in clinic. Your cost-share will be waived for the following services when the purpose of the procedure is contraception, as documented by your provider on the claim: • Professional physician services for FDA-approved female sterilization procedures, regardless of the location of service. • Professional physician services for fitting, implantation and/or removal (including follow-up care) of FDA-approved contraceptive devices provided during a physician office, home or walk-in clinic visit. • FDA-approved implanted contraceptive devices. • The following FDA-approved generic and brand with no generic equivalent prescription hormonal and barrier contraceptive methods and devices: patches, rings, contraceptive injections, diaphragms, cervical caps, cervical shields, female condoms, sponges and spermicides.

BENEFIT	PREMIUM COST-SHARE
	Cost-share is waived for professional services provided by a pathologist, dermapathologist or radiologist. You pay $800 deductible and 25% coinsurance for sleep studies in a physician's office.
POST-MASTECTOMY SERVICES	You pay $800 deductible and 25% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($30) or a specialist copay ($60).
PREGNANCY, TERMINATION	You pay $800 deductible and 25% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($30) or a specialist copay ($60).
PREVENTIVE SERVICES	Your cost-share is waived, regardless of the (in-network) location where services are provided, if: • You receive one of the services listed in "Benefit Description" under "Preventive Services" in the **Description of Medical Benefits** section; • The procedure code, the diagnosis code or the combination of procedure codes and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive; and • The primary purpose of the visit at which services were provided was for preventive care.
RECONSTRUCTIVE SURGERY AND SERVICES	You pay $800 deductible and 25% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($30) or a specialist copay ($60).
SKILLED NURSING FACILITY (SNF) SERVICES	You pay $800 deductible and 25% coinsurance.
TELEHEALTH SERVICES	You pay a $30 copay.
TELEMEDICINE SERVICES	You pay the cost-share amount that is applicable to the service being provided via telemedicine. Your location and the provider's network status determine the amount of your cost-share.
TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES	You pay $800 deductible and 25% coinsurance for professional services provided in a facility and for inpatient and outpatient facility charges. For physician office visits, you pay a PCP copay ($30) or a specialist copay ($60). You pay a $60 copay per member, per provider, per day for chemotherapy and/radiation therapy services.
TRANSPLANT AND GENE THERAPY TRAVEL AND LODGING	Your cost-share is waived.
URGENT CARE	You pay a $60 copay per member, per provider, per day for services from a provider contracted with the Plan to provided urgent care services.

Services by any out-of-network ancillary provider will be paid at the in-network level and based on billed charges, when both the facility and operating/attending provider for those services are contracted.

Summary of COVID-19 Related Benefits

The following is a summary of additional benefits available under the Plan, for all levels of coverage (i.e., Value, Core, and Premium), in connection with the COVID-19 pandemic. Except as expressly provided, these benefits will remain in effect only until the end of the expanded benefit period established by the Claims Administrator and will be subject to all otherwise applicable provisions of the Plan, such as benefit maximums, limitations, and exclusions.

COVID-19 Testing

Until the public health emergency declaration by the U.S. Department of Health and Human Services ("HHS") for COVID-19 is no longer in effect, you'll have coverage for the following with no cost-sharing (e.g., no copay, deductible, or coinsurance) whether provided in- or out-of-network:

- COVID-19 tests (as defined below), including both the testing product and the administration of the test, ordered by a provider and performed according to Center for Disease Control guidelines
- Related items and services (as defined below)

A "COVID-19 test" is an in vitro diagnostic test (including a serological test) for the detection of SARS-CoV-2 or the diagnosis of COVID-19 which is:

- Approved by the Federal Drug Administration ("FDA")
- Developed by a manufacturer who has requested (or intends to request) emergency use authorization from the FDA
- Developed by a State or
- Approved by the Secretary of HHS

"Related items and services" are items and services which are:

- Provided to a member during a health care provider office visit (including in-person and telehealth), an urgency care center visit, an emergency room visit, or non-traditional care visit (such as a COVID-19 drive-through screening and testing site where COVID-19 testing is administered by licensed health care providers) that results in an order for (or the administration of) a COVID-19 test, and
- Relate to the furnishing or administration of the COVID-19 test or the evaluation of the member's need for the COVID-19 test, as determined by the member's health care provider to be medically appropriate for the member.

COVID-19 Treatment

You'll have coverage for medically appropriate COVID-19 treatment, subject to applicable cost-sharing.

Telehealth Services

You'll have access to and coverage for all BlueCare Anywhere telehealth services with no cost-sharing (i.e., your cost-sharing is waived).

Telemedicine Services

You'll have coverage for telemedicine services, subject to applicable cost-sharing.